DOCUMENT RESUME

ED 383 423 PS 023 190 .

TITLE	Who's Minding the Baby? Quality and Availability Problems in Child Care for America's Children. Hearing before the Subcommittee on Regulation, Business Opportunities, and Technology of the Committee on Small Business. House of Representatives, One Hundred Third Congress, Second Session (Portland, OR, December 9, 1994).
INSTITUTION	Congress of the U.S., Washington, DC. House Committee on Small Business.
REPORT NO	ISBN-0-16-046799-3
PUB DATE	95
NOTE	180p.; Serial No. 103-111. Contains many pages of small print.
AVAILABLE FROM	U.S. Government Printing Office, Superintendent of Documents, Congressional Sales Office, Washington, DC 20402.
PUB TYPE	Legal/Legislative/Regulatory Materials (090)
EDRS PRICE	MF01/PC08 Plus Postage.
DESCRIPTORS	Child Caregivers; Day Care; *Educational Attitudes; *Educational Quality; *Family Day Care; Hearings; Parents; Professional Development; Program Improvement; State Officials; Teacher Education
IDENTIFIERS	Child Care Needs; Congress 103rd; Day Care Licensing

ABSTRACT

These hearing transcripts present testimony concerning the quality and availability of child care in the United States, focusing on ways to improve the quality of home-based child care. Much of the testimony addressed the need to provide increased educational and training opportunities for home-based child care providers and to better regulate and inspect home-based providers. Testimony was heard from: (1) the Assistant Secretary for Children and Families, U.S. Department of Health and Human Services; (2) the Associate Director of Income Security Issues, U.S. General Accounting Office; (3) the administrator of the child care development division of the Oregon Employment Department (4) a community college department chair; and (5) two home-based child care providers. Additional materials from the U.S. General Accounting Office and parent advocacy groups are included. (MDM)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED 383 423

WHO'S MINDING THE BABY? QUALITY AND AVAILABILITY PROBLEMS IN CHILD CARE FOR AMERICA'S CHILDREN

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☒ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

HEARING

BEFORE THE

SUBCOMMITTEE ON REGULATION, BUSINESS OPPORTUNITIES, AND TECHNOLOGY

OF THE

COMMITTEE ON SMALL BUSINESS
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

PORTLAND, OR, DECEMBER 9, 1994

Printed for the use of the Committee on Small Business

Serial No. 103–111

U.S. GOVERNMENT PRINTING OFFICE
85–527 CC WASHINGTON : 1995

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-046799-3

PS 023190

BEST COPY AVAILABLE

COMMITTEE ON SMALL BUSINESS

JOHN J. LAFALCE, New York, *Chairman*

NEAL SMITH, Iowa
IKE SKELTON, Missouri
ROMANO L. MAZZOLI, Kentucky
RON WYDEN, Oregon
NORMAN SISISKY, Virginia
JOHN CONYERS, JR., Michigan
JAMES H. BILBRAY, Nevada
KWEISI MFUME, Maryland
FLOYD H. FLAKE, New York
BILL SARPALIUS, Texas
GLENN POSHARD, Illinois
EVA M. CLAYTON, North Carolina
MARTIN T. MEEHAN, Massachusetts
PAT DANNER, Missouri
TED STRICKLAND, Ohio
NYDIA M. VELAZQUEZ, New York
CLEO FIELDS, Louisiana
MARJORIE MARGOLIES-MEZVINSKY, Pennsylvania
WALTER R. TUCKER III, California
RON KLINK, Pennsylvania
LUCILLE ROYBAL-ALLARD, California
EARL F. HILLIARD, Alabama
H. MARTIN LANCASTER, North Carolina
THOMAS H. ANDREWS, Maine
MAXINE WATERS, California
BENNIE G. THOMPSON, Mississippi

JAN MEYERS, Kansas
LARRY COMBEST, Texas
RICHARD H. BAKER, Louisiana
JOEL HEFLEY, Colorado
RONALD K. MACHTLEY, Rhode Island
JIM RAMSTAD, Minnesota
SAM JOHNSON, Texas
WILLIAM H. ZELIFF, JR., New Hampshire
MICHAEL A. "MAC" COLLINS, Georgia
SCOTT McINNIS, Colorado
MICHAEL HUFFINGTON, California
JAMES M. TALENT, Missouri
JOE KNOLLENBERG, Michigan
JAY DICKEY, Arkansas
JAY KIM, California
DONALD A. MANZULLO, Illinois
PETER G. TORKILDSEN, Massachusetts
ROB PORTMAN, Ohio

JEANNE M. ROSLANOWICK, *Staff Director*
JENIFER LOON, *Minority Staff Director*

SUBCOMMITTEE ON REGULATION, BUSINESS OPPORTUNITIES, AND TECHNOLOGY

RON WYDEN, Oregon, *Chairman*

IKE SKELTON, Missouri
TED STRICKLAND, Ohio
NORMAN SISISKY, Virginia
JAMES H. BILBRAY, Nevada
MARTIN T. MEEHAN, Massachusetts
WALTER R. TUCKER III, California
THOMAS H. ANDREWS, Maine

LARRY COMBEST, Texas
SAM JOHNSON, Texas
JAY DICKEY, Arkansas
JAY KIM, California
PETER G. TORKILDSEN, Massachusetts
MICHAEL HUFFINGTON, California

STEVE JENNING, *Subcommittee Staff Director*
ROBERT LEHMAN, *Minority Subcommittee Professional Staff Member*

CONTENTS

Page

Hearing held on December 9, 1994 1

WITNESSES

FRIDAY, DECEMBER 9, 1994

Aronovitz, Leslie, Associate Director, Income Security Issues, U.S. General Accounting Office, Washington, DC 6

Bane, Mary Jo, Assistant Secretary for Children and Families, U.S. Department of Health and Human Services, Washington, DC 4

Elliot, Janis, administrator, Child Care Development Division, Oregon Employment Department, Salem, Oregon 9

Ragan, Margaret, Portland, Oregon 37

Suihkonen, Jeanise, Salem, Oregon 36

Weber, Bobbie, chair, Department of Family Resources, Linn-Benton Community College, Albany, Oregon 32

APPENDIX

Prepared statements:
- Aronovitz, Leslie 43
- Bane, Mary Jo 88
- Elliot, Janis 03
- Ragan, Margaret 113
- Suihkonen, Jeanise 115
- Weber, Bobbie 117

Additional material:
- GAO Testimony 119
- Patient Advocate Committee reports 156

WHO'S MINDING THE BABY? QUALITY AND AVAILABILITY PROBLEMS IN CHILD CARE FOR AMERICA'S CHILDREN

FRIDAY, DECEMBER 9, 1994

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON REGULATION, BUSINESS OPPORTUNITIES, AND TECHNOLOGY,
COMMITTEE ON SMALL BUSINESS,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:10 a.m., in Council Chambers, City Hall, 1220 S.W. Fifth Avenue, Portland, Oregon, Hon. Ron Wyden (chairman of the subcommittee) presiding.

Chairman WYDEN. The subcommittee will come to order.

Today, the Subcommittee on Regulation, Business Opportunities and Technology continues its series of hearings on the quality and availability of child care in America.

The U.S. General Accounting Office and the Inspector General of the Department of Health and Human Services presented reports at our last hearing revealing disturbing findings on critical health and safety problems affecting child care in several of the States. These findings ranged from extensive evidence of care-givers with criminal histories to reports of facilities which were unsafe because of negligence or gross mismanagement.

Today, the subcommittee will look at ways and means of helping an important and fast-growing area of child care, home-based providers. These providers need help in establishing better quality services as well as to prepare themselves to tackle what could be a tidal waive of new demands for care in the very near future.

Already, 12 million American youngsters of all economic classes are in full or part-time child care. Only 15 percent of the total are in facilities which are either licensed or inspected by Government agencies.

For the middle-class and the working poor, family or what is known as home-based child care now appears to be the child care option of choice. It is an especially important source for families with young children and poor families.

For example, according to the General Accounting Office approximately 23 percent of employed women use family child care for children between the ages of 1 and 2. An estimated 20 percent of all employed mothers use home-based care for youngsters under 1.

These home-based care-givers generally have a very small clientele, usually six children or less. While Oregon is among the 19

States which regulate these providers, a recent Government analysis indicates that as much as 92 percent of this care is unregulated and uninspected.

Quality of care is a concern of millions of single-parent households and of families in which both parents must hold down jobs to make ends meet. Beyond the needs of these families, quality and affordability of care is a fundamental component of the smooth functioning of our Nation's economy.

Finally, child care in this country is a $20 billion per year business, one of the fastest growing sectors of small business specifically. I believe that making child care services more readily available is also the key to getting welfare reform accomplished in a responsible fashion. At the core, there is no element more important in helping millions of families move from the welfare rolls and into self-supporting employment than is child care.

This country wants to keep families intact. Quality child care is essential to our society's least economically advanced kids. Good care, which in our view includes decent nutrition, minimal preventive health care services and education and social training skills, can help kids most at risk of continuing the welfare cycle.

As one of our witnesses will state today, welfare reform is a two-generation issue. Efforts must be made to help both those who are on welfare and their youngsters break the historic chains of poverty.

In the vast majority of cases, home-care providers are doing their best with some very limited resources. According to the GAO, these folks need better care-giver training programs, more instruction in nutritional assistance in providing meals and more outreach programs so that they can help provide basic health care services important to children such as immunization and hearing and vision testing.

As noted in the report done for the subcommittee by the General Accounting Office, several States, specifically Oregon, have taken the lead in driving innovative local programs to meet some of these needs.

In Hood River County, two county health organizations and a local child care resource agency provide consultations on children's health and nutrition to family child care providers in the community. A public health nurse makes home visits to providers, answers questions over the telephone and conducts training sessions on health and nutrition issues. The funding for this service comes in part through Federal block grants.

In Salem, home care provider networks and mutual assistance programs for training are being developed in part through a grant from the Dayton-Hudson Foundation.

The subcommittee is pleased that Ms. Bobby Weber, from Linn-Benton Community College will be here to talk about these efforts.

In California, the child care initiative project provides a combination of care-giver training and recruitment activities focused on home care providers. Oregon communities are in the process of duplicating this effort with the Oregon Child Development Fund.

In short, with limited funding from Federal, State, and private sources, child care advocates and activists are making the system better. The challenge ahead is whether enough progress is being made to prepare America for the millions of additional youngsters likely to be brought into the system through welfare reform.

It is my view that the States, nonprofit organizations, private businesses and the Federal Government have to build a new partnership to expand access and improve quality of child care services.

As its part of the partnership, the Federal Government can assist in several ways. First, the Federal Government should assist the States to ensure that all States conduct criminal background checks on prospective care-givers. Only 19 of the States now require these checks. A recent Inspector General report surveying actual hirings in several of the States indicate that too many persons now working in day care have significant criminal histories which place our youngsters at risk.

Second, it seems to me that the Federal Government should work more with the business community to promote the use of Federal dependent care assistance plans which, according to Nation's Business magazine which takes special interest in small business issues, this is an excellent approach because it provides a payroll deduction allowing employees to use pre-tax dollars for child care expenses.

Finally, it seems to me that the Department of Health and Human Services needs to play a role in disseminating information to the States and to child care providers about innovative programs that work. I believe that public-private partnerships on the order of the Family-to-Family Program that is in Salem are the way to travel as we move down the road to better child care, and the Federal Government clearly has an interest in getting out information about state-of-the-art child care programs around the country.

It is my view that these objectives can be implemented through this new partnership that I have described and without significantly increasing Federal spending. Hopefully, the next Congress, the business community, community service organizations will mobilize behind this effort.

Today, we are going to hear more about these innovative partnerships from Janis Elliot. She is Oregon's chief State child care administrator, and she will be on our first panel.

I would like to also note that Ms. Elliot came to Washington, DC, last winter on a day that was perhaps the all-time record breaker with respect to snow and ice, showing especially great commitment to the cause, and we are very happy to have her.

We also want to offer special thanks to Leslie Aronovitz, who represents the GAO, who has done considerable work for this community but especially on child care, and we commend her for her recent report.

We want to extend a welcome to Mary Jo Bane, an Assistant Secretary of Health and Human Services in the Clinton administration. Ms. Bane is the point person in the Clinton administration for efforts with respect to child care. She has trekked across the country literally for 24 hours to be with the subcommittee today. We want to thank her as well for making that special effort.

I have always said that representing Oregon in the Congress is a wonderful honor, and I love being home. I just wish I could avoid the air travel. We are very glad that you are here.

Let's call our first panel: Ms. Bane, Ms. Aronovitz, and Ms. Elliot. If all of you will come forward, we will have short formalities. I'm going to make your prepared statements a part of the hearing record in their entirety. We do have plenty of time for you to touch on the key points that you would like to address.

It is the practice of this subcommittee to swear all the witnesses that come before us. Do any of you have any objection to being sworn as a witness?

[Witnesses sworn.]

Chairman WYDEN. All right. Let us begin, then, with Ms. Bane. Again, I want to thank you and the administration for the cooperation that has been shown this subcommittee, not just on this child care issue but a variety of other human services issues. Why don't you proceed?

TESTIMONY OF MARY JO BANE, ASSISTANT SECRETARY FOR CHILDREN AND FAMILIES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Ms. BANE. Thank you, Mr. Chairman. It's a pleasure to be here. It's a special pleasure to share with a panel this morning with Leslie Aronovitz and Janis Elliot.

The GAO report and Janis Elliot's testimony show that there are really some very good things going on in child care and especially here in Oregon, which has always been an innovator and a leader in this issue as in so many others. So, it's a pleasure to be here.

I will just summarize the testimony that we have submitted for the record.

This morning, all across this Nation, millions of young children are participating in some form of child care while their parents are working or receiving training or going to school. Some are in their own homes, others are in family day care homes, and still others are in child care centers.

There has been a dramatic increase in labor force participation among mothers, especially mothers of young children, and that has heightened the attention, as you noted, to child care in the recent years. That makes it more critical for the Federal Government in partnership with the States, with communities, with providers and with parents to work toward assuring that all child care is provided in safe, nurturing and healthy settings.

As you noted, I am the Assistant Secretary for Administration for Children and Families and therefore responsible for the administration of ACF child care programs. I will focus my remarks on those programs and on some of the initiatives that we have underway.

The Administration for Children and Families administers a variety of programs that help low-income families obtain child care service. ACF child care services focus on assisting individuals in low-income families who are employed, who are in education and training for employment and who need child care in order to achieve self-sufficiency.

ACF programs also serve children who need child care for protective services. The Child Care and Development Block Grant provides funds for States, territories and tribes for child care assistance. Title IV–A of the Social Security Act provides Federal funds to States for child care for AFDC recipients, transitional child care for recipients who are leaving the welfare far rolls and at-risk child care for families for whom child care can be the means of getting them off of the welfare rolls.

This care is subject to the applicable standards of State and local law. All providers receiving funds under the block grant program must meet health and safety requirements that are set by the States in certain areas, including the prevention and control of infectious diseases, building and premises safety and provider training. We know that over half the States have elected to expand these requirements to child care funded under IV–A.

We have tried to take steps over the last year to ensure better consistency and coordination among child care programs. Last spring we developed and published a Notice of Proposed Rule Making in the Federal Register which is designed to remove some of the barriers to coordination of child care services and to support States, territories and tribes in improving child care quality. We hope to publish final regulations this winter. We got lots of comments on it which we are working with right now.

We are now finalizing plans to consolidate the Federal administration of the four main child care programs into a Child Care Bureau. This will be able to provide national leadership and direction to improve quality, supply and affordability and serve as a focal point for child care within the Federal Government, which is really very important.

In terms of supporting child care quality, we are strongly committed to working with our partners to improve the quality and supply of child care for children and families through working, as you noted, in partnership with grantees, communities, providers and the private sector. We know that quality care depends on adequate health and safety standards, depends on proper monitoring and enforcement and depends on a sufficient supply of well-trained and supportive staff.

Access to quality child care is obviously critical to ensuring the health and safety of children, promoting healthy child development, to ensuring that all children are ready for school and guaranteeing parental choice of care and, of course, providing parents with the peace of mind and the continuity and stability of care that they need for them to succeed at work and maintain their economic independence.

The Child Care and Development Block Grant is the principal source of Federal funds to strengthen the quality and to enhance the supply of child care. Under the block grant program, 25 percent of the funds must be set aside for activities that improve the quality of child care and that expand the supply.

Activities to support quality include resource referral assistance, grants or loans to assist providers in meeting State and local regulatory requirements, monitoring of compliance, care-giver training and improved salaries for child care staff.

I was delighted to see in the GAO report and in Janis' testimony that block grant funds are, in fact, being used for interesting and innovative approaches to helping family day care through networks, through provider training, through a full variety of things.

Now the Title IV–A child care funds don't include a similar set-aside for quality, but IV–A administrative funds may be spent on activities that serve IV–A families, including counseling of parents, resource and referral activities, training of staff and so on. In addition, block grant funds can be used to improve the care for children subsidized by the IV–A Program, and many States are making use of that opportunity.

The Administration for Children and Families has taken a number of steps over the past years to help improve the quality of care. We've sponsored three national child care conferences for State and tribal child care administrators, for Head Start program staff, for educators and for child care advocates, and that's been an important mechanism for doing what you mentioned in your opening statement, Mr. Chairman, to spread the word about innovative programs and help people learn from each other.

We have sponsored 10 regional symposia for State administrators and five tribal workshops to provide training and technical assistance on a variety of topics.

We have collected information from States on health and safety requirements and on their use of block grant funds for expanding and establishing and conducting the programs and information on how they are improving the quality of care so that we can help make that information available to other grantees.

In the works we have an institute focusing on school age child care, two national meetings and, perhaps most importantly, on-site technical assistance for grantees on a range of operational issues. We will be convening regional forums focusing on health and safety, and we will be putting in place a National Child Care Information System, and we have worked together with both the Head Start Bureau and the Maternal and Child Health Bureau to see how we can work together on improving the quality of child care.

So I think that in all segments of this world there are lots of innovative activities going on which we are proud to be a partner.

In closing, I want to thank you again for your interest and commitment, and we are happy to be here and to answer your questions.

Chairman WYDEN. Thank you very much, and that's very helpful. You are going to be one of the most busy people in Washington, DC, over the first few months of 1995 as the issues of welfare reform and child care intersect and the contract is debated in the Congress. We will have some questions here in a moment. We thank you.

[Ms. Bane's statement may be found in the appendix.]

Chairman WYDEN. Let's go down to Ms. Aronovitz. Welcome.

TESTIMONY OF LESLIE ARONOVITZ, ASSOCIATE DIRECTOR, INCOME SECURITY ISSUES, U.S. GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Ms. ARONOVITZ. Thank you for inviting here today to discuss the ways in which children who are cared for by neighbors and friends can receive the highest quality care possible. As you know, our report that you released this week discusses our findings about family child care initiatives nationwide that are working with providers to enhance the quality of care they give children.

Family child care is a very popular option, as you said, for low-income families because it can provide a lot more flexibility than child care in formal settings. Unlike many centers, family child care providers will care for infants and toddlers and accommodate parents's nontraditional work hours.

Despite family child care's wide use, questions have been raised about the quality of care provided in these settings. Often, family child care providers do not have the money or time to attend professional development activities and are not linked to networks or support groups that can supply toys, other materials and help when difficult situations arise.

Quality in family child care is so important, as it is in all child care settings, because it could contribute to children's later success in school and, in conjunction with other supports, may break the cycle of intergenerational poverty.

At your request, we identified public and private initiatives to enhance the quality of family child care, their sources of funding and some of the implications of our findings for welfare reform. It was a very exciting undertaking, and the staff that worked with me on this project walked away from these of some initiatives totally motivated and very, very reassured about some of the activities that are occurring.

We found 195 initiatives nationwide seeking to improve family child care quality. We couldn't find any single database that contained all the initiatives, but we were able to, through literature searches and through a call on Internet and talking with a lot of people in the field, put together this database. Today I would like to discuss a few of them that worked toward improving the quality of family child care in Oregon and around the country.

We found that many organizations sponsor activities that work with family child care providers to improve the quality of care they give to children. While their purposes approaches and methods of working with providers differ, all these initiatives have the overarching goal of supporting providers.

These organizations generally focus on three different activities. They foster quality care by establishing support networks, by training, recruiting and providing consumer education initiatives and through health initiatives.

We found a variety of examples of these approaches in Oregon and other States. The representative of one of them, the Family-to-Family Project, is testifying for you later this morning, I understand.

Our site visits to 10 other initiatives found some really interesting things. We saw care-givers who were very enthusiastic about working with children; a great number and variety of toys, books, and playground equipment that seemed to be on the premises; and the excitement with which the providers talked about the new and continuing training activities they have because of their participation in some of these initiatives.

For example, in Atlanta we visited the homes of three providers who are participating in Save the Children's Neighborhood Child Care Network. These homes were well equipped with toys and educational materials. But one of the best toys that we found was a computer that each of the providers were able to get through the program that had a software package that was geared toward teaching preschoolers how to read.

We saw confident little 3- and 4-year-olds rushing, totally unintimidated by the technology, to show us how they know how to use the computer software. We don't care and we don't know whether they will learn to read from the particular computer program, but we do know that they will be better able to handle the technology that is becoming more prevalent both in our schools and our workplaces.

Mr. Chairman, you alluded to an initiative that was reforging ties between the public health and the child care communities. This initiative is the American Public Health Association project being conducted in Hood River, Wasco and Sherman Counties.

Given the large number of children being cared for in centers and in other people's homes, especially infants and toddlers who don't have their immune systems totally developed and fully matured and are much more prone to injuries, there has been much discussion over the urgent need for child care and public health to work much more closely together. This project is doing just that through the two county health developments and a local resource and referral agency.

You mentioned that a public health nurse makes home visits and consults with family child care providers over the telephone. She also distributes useful items that range from educational pamphlets to smoke detectors and safety latches.

The day we visited, a nurse had just received a call from a local family child care provider who didn't know how to treat a child's pin worm infection. The nurse was going to visit the provider to explain a course of treatment and examine the other children. Interestingly, the provider found out about the project through a training session sponsored by the local resource and referral agency.

Public health is so important because more and more children, especially low-income children, do not have easy access to preventive health care. Consequently, child care providers are having to deal with much more serious health problems of children in their care besides just pin worm.

We found that the funding for the 195 initiatives we identified comes from a combination of private, Federal, State, and local sources. Several of the initiatives we visited were working with relatively small amounts of money and were still able to provide an array of support services to providers that were very impressive. Project directors we spoke with believed that their support to providers made a significant difference in the care that the children received.

The Federal Government's role in child care has traditionally been that of helping parents pay for the cost of child care. However, there are two Federal programs, as Ms. Bane mentioned — she mentioned two of them — the Child Care and Development Block Grant which does put a set-aside, a certain percentage of the money, strictly to improve the quality of child care that is being provided.

Also, the USDA has a program called the Child and Adult Care Food Program, which also, we understand, is a very important source of funding for family child care and other forms of child care.

In terms of how these programs will be affected by reform, most discussions about reform in the welfare system focus on requiring more welfare recipients to either work or attend education or training programs to help them acquire basic skills and become independent of welfare. As a result, the number of children needing child care, particularly very young children, infants and toddlers is predicted to grow. Because family child care is the choice of a significant portion of poor families and also of teen mothers who have the highest percentage of young children, family child care is predicted to grow probably the most.

As we describe in our report, studies have shown that quality child care is critical to children's proper development. Thus, as the demand for child care grows, so too will the need for this care to be of high quality. The initiatives discussed here today and in our report can provide us with valuable lessons about how to improve family child care.

This concludes my prepared statement. I would certainly be happy to answer any questions.

Chairman WYDEN. I'll have some questions in a moment, but I want to thank you for doing a very thorough job. I want to thank you especially for looking at so many Oregon programs as part of this. One thing that we have always been trying to do is be sure that Washington, DC, knows where we are and knows about some of the exciting work that is being done, and I am very pleased at the job that you have done.

[Ms. Aronovitz' statement may be found in the appendix.]

Chairman WYDEN. Ms. Elliot, welcome. It is always good to have a chance to work with you. Please proceed, and I look forward to your testimony.

TESTIMONY OF JANIS ELLIOT, ADMINISTRATOR, CHILD CARE DEVELOPMENT DIVISION, OREGON EMPLOYMENT DEPARTMENT, SALEM, OREGON

Ms. ELLIOT. It was easier to get here this morning than it was——

Chairman WYDEN. You got it.

Ms. ELLIOT. The nice thing about following Mary Joe and Leslie is that they have told a lot of what I could say, so I will glean out of my testimony hopefully the things that I think are the most relevant in terms of the Oregon experience and try to highlight those for you.

As you laid out the demographic situation, we know that very well. The challenges are how do we begin to focus our energies and to pull our resources together in order to make a difference?

In Oregon, although this is not a typology that is necessarily thought out in a lot of detail, we basically focus our efforts in terms of State government and three basic areas. One is a massive commitment to providing services to low-income families. We have been fortunate in the last — within the last decade, more recent years, of really having a substantial State investment in addressing these issues. I cannot underscore how important that is and how challenged we certainly are going to be to maintain that investment in the coming years.

But we have done that with having the Oregon Pre-Kindergarten Program with Partners, with the Federal Head Start program, and indeed the kinds of things that we have been able to do because of having State funds have allowed us to do the innovative projects that in many cases have been looked at nationally around Head Start collaboration.

We think without a doubt we have the most successful or one of the most successful Head Start collaboration projects in the Nation, and they provide substantial service to low-income families.

We have almost tripled our State investment in subsidies for low-income families in conjunction with our self-sufficiency efforts and welfare reform, and I'll talk a little bit later about that. But we are proud of that investment, and it definitely has contributed to being able to achieve those kinds of things.

In my written testimony I think I said that we have about $90 million a biennium going into childhood care and education programs, and in fact, that figure is closer to $130 million a biennium when you look at the investment in Head Start.

The other area that we focus our State efforts on in terms of State government's role is the whole issue of regulation. I think we are coming to a better understanding of what regulation — what role regulation plays in this State.

I think that it's very important to understand that regulation is an absolutely necessary component of achieving quality, but it's not sufficient. That we'll never get where we are going if we look only at regulatory strategies; that we have to develop a menu, if you will, of approaches, training and support to providers and technical assistance and consumer education so that parents know what they are looking for and how to maintain quality and making choices. Because I absolutely believe that we will never get there if we look only at regulation.

But we cannot disregard the importance of regulation and, as you know, in the last legislative session Oregon made the step back into regulation of family child care with the institution of the registration program for family child care.

It is a tremendously challenging program, and it is not an easy step to take. When you move from a voluntary system to a mandatory system there are a lot of issues that come up and particularly as we begin to tie financial incentives to that regulatory system. For example, we are looking at requiring all of our subsidized providers in the State of Oregon to be registered, and we know that will bring up incredible kinds of issues.

We have major workload issues in regulation, and I know that can sound very bureaucratic and State administrated, but it is not to be disregarded. We have had a 110 percent increase in our licensed child care facilities in the State of Oregon over the last 10 years and have had a zero increase in staff to be able to carry that out. While I do not believe regulation alone gets us to quality, the role that regulations staff play in providing consultation, helping people understand what the rules are and how they can comply with them is tremendously important. We are struggling with that issue, particularly as we have taken on now the charge of registering what we estimate will probably be 15,000 to 20,000 family child care providers.

So while we're doing wonderful things and I agree it's nice to have people from out of State talk about the good work we're doing, it's not without caveats, if you will, in terms of challenges.

But the other piece that I think is tremendously important of what we have done in Oregon, that I think is a part of a major contribution to the uniqueness, is that we have paid attention to the development of the infrastructure. That by building the infrastructure, if you will, the highway of the child care system, certainly through our resource and referral agencies in the State, we have 12 child care resource and referral agencies. They are the backbone of what we are trying to do. Partnered with our community planning process I think it is that that has created the climate and the mechanism, if you will, for the partnerships that you've talked about and that other people have talked about.

This is directly from testimony, but I think it's really relevant, and I want to read it directly. It comes from a report which is produced biennially by the child care system. It's always hard to say who does anything in Oregon because we do it all together as we all have our fingers in the pot for better or worse. But this is from Estimating Child Care Needs in Oregon, 1993, which was published by the Oregon Commission for Child Care.

Most Oregon parents do not purchase supplemental care; they make a variety of arrangements, mostly within the family and without monetary exchange for service. When they do find child care in the wider community, they mostly pay for care themselves. Approximately 90 percent of the Oregon child care system is family financed, and that is true across the country. That is true across the country. That is not unique to Oregon.

The child care system is not like the school system. With some exceptions, we do not live in a society in which Government creates the child care programs and directs families to use them. Rather, we live, work and arrange child care in a more or less free market society in which Government and community agencies can, at best, intervene in rather indirect ways to enhance the ability of families to make favorable choices. The community does indeed need to intervene in this way because the child care market unassisted doesn't work well enough. Large numbers of families report difficulty finding the kind of care they want their children to have, and many parents experience stress balancing work with their care giving responsibilities.

As in other States, Oregon has adopted a policy of trying to improve child care by creating a network of resource and referral services as a focal point and community infrastructure for building supply, informing demand and analyzing emerging needs. This policy recognizes the need for a concerted and well-informed community effort. Parents, businesses, public employers, child care providers, schools, churches, private agencies, foundations and Government all contribute to the development of the child care system. No one of us can do it alone.

It is through those efforts that we are able to begin to look at a more clear picture of what we're dealing with in Oregon. For example, we estimate because of our biennial census that we do at the Oregon progress board that we have 86,000 children under the age of 13 in Oregon who are in family child care. We know about 30,000 of those child care slots. While that's better than the 92 percent that you referred to in your opening statement that still says that we have 56,000 children in care basically every day about whom we know nothing about that care.

It doesn't mean that it's bad. It doesn't mean that it's not appropriate for their children. But it means that we don't have the data that we need to be able to develop our quality initiatives in a more targeted kind of a way.

It also means that parents are very handicapped in being able to access the information they need to know about what is the appropriateness of that care. It certainly makes it difficult for parents to be able to find that care. They rely, unfortunately, upon too many posters on telephone poles or tear-off tabs in Laundromats, and that is not the system that we would like to have Oregon's families have available to them.

Talk about gaps. The gaps are the gaps that have been documented. We have them in common with every other State. Different geographic areas have different challenges in terms of finding care and developing care. We have challenges having care that matches the needs of families.

If you have a 3-year-old and you work from 9 to 5 and you happen to live in a community that has preschool programs, you are probably not going to have a problem finding them. But not many families live their lives according to that predictable schedule. Most — particularly the low-income families who we are trying to assist with our self-sufficiency strategies.

The gap of affordability is a major issue. While we are gratified with the wonderful employer involvement we have in Oregon and we have some employers who have developed very innovative subsidy programs using or tax credit, it by no means addresses the gap of affordability. Less than 31 percent of Oregon's families earn $25,000 a year. Yet it is those families who are most dependent upon paid care and in many cases they are among the least able to be able to pay for the quality that our young children need.

Then, of course, the gap of quality which brings with it all of the issues that we've been talking about.

As I look at the issues around the other States and the points that I believe are most applicable, first of all I believe that everything we are doing in Oregon is applicable. As I talk with my counterparts at national conferences there is a wonderful exchange. I cannot state too strongly the incredible leadership that has been coming from the administration for children and families in terms of promoting networking and providing technical assistance to help us learn from each other. It's tremendously important. But I think there are some things that we have done that stand out.

One of them is clearly the fact that we have brought and included family child care to the table. I do believe there are States where they basically are disregarding family child care.

The challenges of addressing this massive system of small businesses based in communities, largely invisible and difficult to pull into the web because of mistrust of Government, that in many States they've just simply written it off. They've either said we're going to have a very narrow — we'll regulate a certain segment, and everybody else is kind of buyer beware.

In Oregon we have not taken that path. It is not an easy path, but we have taken on the challenge, if you will, and have wonderful partnerships with our family child care providers, and you will hear from one of those providers — only a representative of many.

Our community-based planning. You know the State. Nothing happens in Oregon if it doesn't fly east of the mountains as well as in the valley. Our structure for doing that is something that I think is increasingly appealing.

We just had a visit from a task force in California that was looking at how to structure their child care system. There are a lot of differences. Our numbers are real different. We have people in the whole State only make up a part of the population of some of their biggest cities. But when they looked at our community planning they said this makes sense. This is something we could take back. I think that States can and are doing that.

The data I think is unquestionably one of the most important things, that we do not have to rely on only Federal census data or only extrapolate from large picture kinds of things, that we can begin to really say with some degree of authority, we are looking at 86,000 kids, and who's caring for them, and what is the magnitude of the problem?

I think that is important both in terms of making good investments — because as someone said recently, every dollar spent on child care is a precious dollar, whether it comes out of a parent's pocket, whether it comes out of a tax coffer or a corporate account or a foundation. Every dollar is precious, and we have to use it well.

Our data is helping us to target those resources so that, as GAO reported, we can do wonders with $2,000 or $3,000 if it is applied in some very targeted kinds of ways. So, that is incredibly important.

I mentioned the State support. I am tremendously aware of how blessed we are with a State structure that has made the commitment and investment in recent years to young kids.

I think the other piece that is growing in terms of understanding, and it relates to both the issue of collaboration and partnerships and direction, which is the sense of we are all rowing in the same direction, that we have worked hard in this State over the last 5 to 10 years to build a sense of common vision and value of what we are doing.

So that what in some States are incredibly kind of Balkanized turf wars over this is a Head Start Program. It's not child care. Or this is real child care and this isn't real child care. That we pulled together in this State and essentially said no matter who we are, no matter where we work, whether we are the State government or the Federal Government or a family child care home or a public school or part private child care, it doesn't matter. That we have all the same goal in mind and this is the well-being of our kids and our families, and we use that value system to help us get through the tough times.

There are always tough times, and I think that is something that is getting increasing recognition of really understanding, if you will, kicking into what it means to be value-driven and mission-driven in doing this work and that there are ways that that can be done.

Clearly, I think State government seeing itself as a responsible partner — I think one of the differences in some States is that States see themselves as being the whole banana or nothing. In Oregon we're real clear that in State government we need to be at the table. We need to be there as responsible consumers. We need to make good practices and good policy decisions. But it isn't up to us alone, and we can't do it alone. We have to learn, and we have to have dialogue. That's not a relationship that I think Government has had with our constituents. I think that is part of the trouble that we're in. So, I think that those are the important things.

As I look at welfare reform, there is nothing different about welfare reform than what I said to you about everything that we are doing in terms of building a child care system. The families who we identify as being targeted for welfare reform are no different than other parents. They have different resources. They have——

They may have some particular needs that are posed by the system, and certainly they will have child care needs, and they are going to be more dependent on market care because of that. But they are, as Toni Porter said in her study, like any other parents. They're struggling to do the best job they can in raising their kids.

I get very distressed with the current rhetoric that somehow or other talks about welfare families as other, rather than recognizing that we're all in this together.

We've had an incredible success with welfare reform in Oregon, and we're beginning to reap the benefits that really demonstrate that. You saw in my testimony the chart which I think is one of the most revealing. The day care caseloads are going up, and the ADC caseloads going down. That is no accident.

Although I didn't speak to it, health care reform is obviously key to that. The Oregon health plan is also a major partner in what we're doing and a silent partner in many cases but clearly an important piece.

Chairman WYDEN. Some of us have not given up on the cause of health reform in Washington, DC, either.

Ms. ELLIOT. Well, I hope not. I mean, the best welfare reform is essentially public and economic policies that make it so that families don't have to go on welfare. We know that in Oregon very clearly that people who are entitled to these benefits do not take them because they are so committed to working and supporting their families. So, it is a last resort.

But I do think that some of the things are tremendously important. I feel like I'm speaking to the choir with Mary Jo Bane sitting to my left, because this is what's coming for us out of Federal policies. Consumer education and parent involvement is more than just telling parents what to do but giving them the resources so that they can make more informed decisions in terms of their kids's well-being.

We have got to get Government out of the way. It has to be seamless. This crazy business of if I have blue eyes, I'm qualified for one kind of child care and if I have brown eyes another. Kids are kids are kids, and they need whatever they need wherever they are. We need to have that focus.

Clearly, our direct provider payment has been an important kind of a system. I think that is recognized. I cannot state strongly enough the issue around the market rate. I know how controversial that is because of the fiscal impact to the States, but we will not have access to at least a reasonable level of quality for our low-income families if we don't hold the line on insisting——

That's what I speak about being responsible consumers of care, that what we pay for child care does make a difference in the quality of care and the stability of care. While it may not be on an individual for individual basis, that Mary Jo does better because I pay her $3 an hour than Leslie who I pay $2.50, we know overall that to be important.

So I think that the things that I have talked about in terms of the child care system are the very things that have to come forward as we look at welfare reform. What I would speak for, I guess, is really hoping that we can have that voice be there and that we do have some results in Oregon that can help with that argument.

One thing that is sort of an aside, but it really is not, and it speaks to the USDA food program. Leslie mentioned how the GAO study found the importance of the USDA food program. This is an issue for the Clinton administration.

I'm very concerned about transfers from the USDA food program when we pay for welfare reform. USDA programs in Oregon and I think in other States have not been as fully involved in the partnership as they are beginning to become. But in Oregon the USDA food program — and I know there is someone who can correct my figure — but it is in the neighborhood of $15 million a year that that program puts into our family child care providers.

That means it's into the community. It means that it's into assisting small businesses. But it also means that there are administrative funds that are tremendously important sources of building partnerships working with family child care.

The USDA programs have monitors visiting homes four times a year. If we're talking about trying to create a presence and bring information about immunizations, about health care, about referrals to community resources, all those kinds of things, that's a very, very important program. So, I'm very uneasy about all the talk about what we do with food programs. That we need to take into account how important that is, particularly in family child care.

So — I threw a lot at you, so I'll stop. I'm open for questions.

Chairman WYDEN. Excellent presentation.

[Ms. Elliot's statement may be found in the appendix.]

Chairman WYDEN. I think you know in that regard of trying to streamline Government and making the system work better Oregon had a significant victory this week where the Vice President signed off on what is known as the Oregon Option. One of the three programs that is being looked at initially is in the care of childhood immunization, and I'm very hopeful that we'll be able to extend this in other areas.

When you look at so much of Government and what you see is what amounts to a crazy quilt of eligibility rules, paperwork, administrative arrangements. Now finally with this initiative that the Vice President has launched, we've got a chance to take several of these areas and say, look, Oregon will produce results. The Federal Government will get us out from under some of this numbing red tape.

Ms. ELLIOT. Access to safe and affordable child care is one of the short-term areas targeted by the healthy child provision of the Oregon Option.

Chairman WYDEN. I want to ask you one question to start with because I think that you could make more scientific what is now just my seat-of-the-pants assessment.

My sense is that if child care falls apart — either there isn't good quality child care or there isn't any at all — what happens is that societies starts to play catch-up ball pretty quickly. What happens is the kids then go on to school. They very often don't do well. Kids that don't do well begin to get more caught up in gangs and drugs and sexual promiscuousness and this whole spiral of activities that we know is very damaging to youngsters.

What does your research say on this particular point? What does happen to kids where child care is either poor quality or there isn't any at all in terms of the damage that is done to our society?

Ms. Bane, why don't you start?

Ms. BANE. I don't think we have near enough research to get a definitive answer to that question. It's a very important one. I think that all of our experience and our observations has suggested exactly what you've laid out of how important it is for children to be in good quality child care while their parents are preparing themselves to work.

There have been some studies which have attempted to identify the dimensions of high-quality child care. What is it that is most important about child care? There was a study by the Family Work Institute that I'm sure you know about over this last year which looked at family child care, which was the most important. There are things that are very hard to pin down and regulate — the character of the providers, how they treat their job and so on. But I think we're starting to put together some evidence that that's very important for children and will make a special difference in the lives of disadvantaged children.

Ms. ARONOVITZ. I think it is clear that a lot more research needs to be done, not just in the area of child care but also specifically in family child care. Because of the nature of isolated places it's very hard to do any kind of scientific study where you really get a good sense or a good representation of what's happening in individual child care facilities.

However, we do know of some research that really reinforces what you are saying. Recently, the Carnegie Report called Starting Points that was issued this year, which really talks about how incredibly important early childhood development is, it says that especially for poor children — the research shows that children under 3, from the time they are born to the time they are 3, that time is so incredibly critical to their later development, their whole neurological development and their cognitive achievement later in school.

So it's one of the studies that absolutely——

Chairman **WYDEN**. Is that the most recent major study that you think of?

Ms. **ARONOVITZ**. That is one that is the most recent that we could find. But then, of course, you have the Perry preschool research, one of the most significant longitudinal studies that tracked children over long periods of time. They have been able to document such positive outcomes in people's adult lives when they have very good quality child care and attention and interaction when they were very young.

There is scientific evidence that there is a much lower rate of unwed births, lower rate of involvement with the criminal justice system, much fewer welfare recipients later in life and also a higher rate of high school completion.

So some of the studies are showing that the critical years when a child is born to the time they are 3 not just affects their immediate development but really takes them through school and later in life in terms of their ability to achieve.

Chairman **WYDEN**. You are making the argument that this is going to be fundamental to businesses in terms of having the workers they need to compete and be competitive in local markets. It's not just a question of whether you want to be a bleeding heart and do something nice for kids.

Ms. **ELLIOT**. I think there's another piece in there where we have walked away from the whole child care issue has been with school-aged kids because we operated on some kind of assumption that once kids went to school that school took care of it. There is some growing body of research that looks to essentially what I call the middle-aged child experiences and subsequent involvement in gangs, teen pregnancy, drug and alcohol involvement, and those kinds of, if you will, social costs that come from essentially neglecting kids.

That's part of why the crime bill, for example, began to include some issues around prevention, recognizing that quality — we call them child care programs because 8, 9, and 10-year-old kids don't like to think of themselves as needing child care — but quality supervision and developing appropriate activities for those kids in that 8, 9, and 10-year-old range has a correlation to what happens to them in adolescence and so there is research that is beginning to make that tie in, too.

Chairman **WYDEN**. Let me ask you some questions.

Ms. Bane, to start with you, one of the things that I think was very helpful about the way you have taken on this enormous task is that you have been trying to work with the States especially to try to strengthen the partnership there. Tell me a little bit about your plans in terms of trying to work with the States and the kinds of efforts that are under way there in terms of the administration and the States.

Ms. **BANE**. I mentioned some of it in my testimony, and I think that the partnership notion really is important. I loved the statement in Leslie's testimony where she said the slogan in Oregon is that the child care works when you work together. I think that is true in the national level as well as the State level.

I think that the building blocks of the partnership, of course, are the Federal funding that is provided, especially the funding that is provided through the block grant and that has the set-asides for investments in quality and investments in supply.

I think that we also have a role in reviewing State plans, plans of grantees, in doing program reviews and helping States and other grantees understand how well their programs are working and where they need to improve them. I think we have a big information exchange and a technical assistance role which we try carry out through conferences and regional meetings and on-site technical assistance and working together.

Leslie also talked about how important it is that we all have a shared sense of vision and a shared mission as we work in these areas. I think one of the main things that the Federal Government can do from its leadership role is to help everyone see the vision of child care in all its diversity but with an emphasis on the needs of children and families and that we can help out in that area, too.

Chairman WYDEN. Turn, if you would, specifically to the relationship of your office and the in-home providers. What do you see as the role of your department in terms of trying to assist those folks?

Ms. BANE. Well, again, I think it is working together with all our partners, with the States and private grantees, with private businesses, as you have mentioned very often, to provide the kind of information and the kind of help that family day care providers need.

I would be interested in Leslie's response to this, but it has looked to me as though the existence of the child care block grant certificate program has had the effect of bringing a lot of family day care homes into the system, if you will. Because in order — about two-thirds of the service money under the block grant goes out in the form of vouchers or certificates to parents, and for a child care provider to redeem that certificate they obviously have to make themselves known to the organization that is doing the redeeming.

That's providing an opportunity and indeed a requirement for States to legitimize more, to at least register many, many more child care home providers. I think that that, plus the funds that are available under the block grant to invest in quality and to invest in research for networks and to invest in parent education, which is of course crucial here, has given us a good start both on knowing more about family day care homes but also helping to improve the quality of their services.

Chairman WYDEN. Ms. Aronovitz, would you like to add to that? I guess what Ms. Bane is saying is that the block grant has the potential to be a value on kind of three fronts. I mean, there are some Federal resources that are available. At the same time, it kind of brings out some of the people who make up what Ms. Elliot has said is this group that are not well known. Then, third, it has some benefit in terms of parent education.

Those strike me as all very laudable kinds of uses. Is that your sense, Ms. Aronovitz? What have been your findings with respect to this newer program?

Ms. ARONOVITZ. When we originally undertook this study, looking at the initiatives that are current around the country, we were a little bit surprised that they weren't all this well known or that publicized. It took us some real digging to be able to identify some of the initiatives that we found.

In some cases these initiatives are being replicated in other places, but we feel that, as Ms. Bane said, the Federal Government has a very important role in being a clearinghouse for States to help encourage best practices and to disseminate information about what different States are doing.

I think what Ms. Elliot said about how Oregon cares so much in terms of the value system that they share and the way the decisions are made at the community-based level, those are very important lessons that other States really would like to play on and know about. So, the Federal Government being a clearinghouse, I think, is very important, and it sounds like clearly they are going in that direction.

I also think that the Federal Government has a very important place to play in encouraging these kinds of initiatives. I really appreciate you having this hearing today because I think that it makes people realize how important these initiatives are. They don't involve a lot of money, a lot of Federal spending, for sure. With a little bit of money in some of the places we went to you could get just incredible results.

Also, these initiatives are helping States to do really creative things and to empower family care providers in ways that they never really felt they could be.

One of the things that was so striking about our teams in going to some of the initiatives was to see how proud the family child care providers were in the way their facilities looked, the way their homes looked, the kind of toys and other materials that their homes had. They were so proud to be able to share how much they knew about safety and nutrition.

It's those kinds of providers that we're putting the future of our children into, and they need whatever supports possible to make that happen. To the extent that the Federal Government could capitalize on public and private partnerships to encourage those kinds of initiatives, we think that's critical.

Ms. ELLIOT. I point I think — you talked about how I think in Oregon we understand that we're not all bananas but we play an important role. I think that the role that subsidies play influencing quality is important because if there's one or two children within a family child care program and the subsidy drives something to improve quality by its requirements or by the technical assistance that is brought in in partnership with that, then the other children who are in that program, in that home, even though they may not be eligible for a subsidy, are also benefiting from that requirement.

It's an example, I think, of what I said about the State understanding what our role is as a partner. That we don't disregard it just by saying just because we're only subsidizing whatever percentage it may be of the population doesn't mean what we do with our dollars doesn't have an incredibly important impact for all of the children in families in the State.

So I think that the understanding of subsidies and particularly with the certificates' program, where essentially Federal policy has said we're going to subsidize kids where parents want them to be, not in some centralized option; where we say, if you get a subsidy, this is where you go, I think it has tremendous impact. It's been challenging. It's not been easy. It isn't clearly black and white, but I think it has done a lot to move along the overall quality of the system.

Chairman WYDEN. Ms. Bane, let's turn a little bit toward what's coming up. I want to shift away from some of the overheated politics to some of the things that I think need to get out on a bipartisan basis, are going to present some issues.

There is something like $8 billion in the system now in terms of the services, tax breaks, that kind of thing. Any version of welfare reform is going to significantly increase the number of youngsters that are going to be part of this system, and a number of the estimates indicate something like 50 to 75 percent within 2-year period. Is the system in a position to be able to handle this kind of tidal wave of additional people who is likely to come?

Ms. BANE. It's actually interesting to look back over the years since 1988 when the Family Support Act was passed. The Family Support Act really started welfare reform by requiring participation of welfare recipients in education and training programs in a quite significant way. There are about 600,000 welfare recipients who are participating in the JOBS Program as result of that legislation and of State programs, and that's been a quite important increase over a 6-year period. The child care system in most places has moved along and been able to meet demand — better in some areas than others, obviously.

I think what we are likely to see with welfare reform is a continued increase, obviously, in the number of welfare recipients who are participating in going to work. But I think that we can learn a lot from the experience of the last couple of years. Our sense is that there are certain areas of child care — and, again, you may want to get some comments from other people — but where the system is in a less good position to respond.

It has seemed to be the case over this 6-year period that I'm referring to that child care for 3- and 4-year-olds, the preschool group, has actually responded pretty well. Where we tend to see shortages in supply are for infants for after-school care and for some of the specialized kinds of care that Janis noted earlier.

Chairman WYDEN. Let me make sure that I got that. Your sense is that infants and after-school care and there was a third area?

Ms. BANE. The third area was kind of a miscellaneous area that reflects the fact that many parents do not work, as you know, to a standard shift. So, care that is offered at odd hours or different area hours. That tends to be in less plentiful supply.

You have unevenness in supply was one of the reasons that the block grant made available a certain proportion of funds for investment in supply of various types of care. It is going to be very important that we all work to use that money very carefully to build-up and to try to direct the kind of supply development that we're going to need as the trend continues.

Chairman WYDEN. Is there any way — and let us again set aside all the politics of this — that the system can now meet this huge upcoming additional demand without some additional resources, be they private, be they State, be they partnership efforts?

Ms. BANE. I think it's clear that the expansion — I mean, again, it's not just in the welfare system but as we have seen a terrific trend over the last two decades of more and more mothers in the labor force, the child care system has had to respond, and it will continue to have to do so. That's obviously going to be very challenging for everybody. As you know, it will require private resources, public resources and so on as we try to meet that demand.

Ms. ARONOVITZ. I think your question is very, very compelling, and I'm very happy that Ms. Bane's here to answer it, because it really is her area.

But one thing that strikes me as she talks is that the areas that she describes, that you describe as areas that are most vulnerable in terms of needing more slots and being able to fulfill the demand, really deal with the kinds of programs that family child care in particular can provide to mothers.

We're talking about a lot more flexibility than formal child care settings. We're talking about family day care that can supply part-time hours or late hours. A lot of welfare recipients work the night shift or low-income people work very nontraditional hours. After-school care. Infants and toddlers. A lot of child care centers don't take children that are less than a year old. It's a very important area that needs to be filled in terms of demand.

I talked about nontraditional shift hours. Also sick children. Very often in a formal child care center if a child is mildly sick the parent has to stay home with the child because they can't bring them to the center. Whereas a family child care provider would take that child in.

Then the whole area of special needs children.

So one other — well, there are actually a few other, really, issues that, depending on how welfare reform is targeted, could also affect family child care even more. It has to do with how much the reform provision will target teen moms, because teen moms are the ones that have the youngest children, and, therefore, the infants and toddlers end up being the most vulnerable and the most in need of family child care.

Also it's very difficult, often, when you are in neighborhoods where people were very comfortable because of maybe for cultural reasons or language reasons or barriers to transportation where very often — it's hard to get your child to a day care center, you can keep them in the neighborhood.

So, for all these reasons, I think that question is so compelling, and it's one that I'm sure we're not going to be able to answer for a while until we know more specifically about what the reform provisions are going to contain.

Chairman WYDEN. I want to give Ms. Elliot a chance.

I know more than anything it's important for policymakers to understand what the needs are going to be. There is going to be this really overheated debate about one approach versus another. We've seen some evidence of it. But I think it's important that what both of you and Ms. Elliot have done is to discuss about it for policymakers for purposes of this debate just where those needs are going to be. Because that's not getting out as well.

Ms. ELLIOT. The other piece of that is that we have to understand the market and we have to understand what the business of family child care is. I think as policymakers we don't understand that very well.

On the one hand while we talk about the flexibility — and I agree, I think that family child care is a segment of the industry of the future. Not that it replaces the other components, but as we talk about flexibility and part-time care and evenings and sick care we also have to understand that if people are going to invest in family child care as small business operators and make them successful small businesses where they are providing quality services and they are intentional——

That is one of the things that Ellen Galinsky noted in her study of family child care was essentially the issue of intentionality. The people who are choosing to do this work because it was their work at this point in their life were the ones that did a better job with kids. That we cannot lightly say, well, our rates will be hourly instead of daily or monthly because it's more convenient for us. We can save money by paying you hourly rates. Because then providers who are the intentional providers that we want to nurture and build what we're doing can't afford to operate their business. They are already subsidizing our child care system in their wages. We know that center care across the board, that the biggest source of subsidy in child care is coming through low wages from providers.

But it's particularly key with family child care, because while we refer to it as informal, increasingly it is really not informal. It's a formalized system of small business operation. That's why we continually have to learn what the reality is. As policymakers we are real far removed from that because, again, it's hard for us to get to that information.

We have to have family providers participating with us so that they can say, wait a minute. If you move to an hourly policy, you have to know what that does to my business. I can't stay in business if you do that. If I go out of business, who is going to move in and take my place? We don't want people who are slipshod about operating in this business and caring for our kids.

Chairman WYDEN. Ms. Bane, on the matter of your efforts to standardize procedures and requirements in your department, could you maybe give us some examples in terms of how this is helping to stretch resources and improve services?

Ms. BANE. Well, as you noted and other people have noted, there are a lot of different child care programs for a lot of different reasons, and they have a lot of different rules governing them. Much of that, as you know, is statutory, and we will be looking forward to working with Congress on those issues.

There are some things that we felt that we could do through regulation and putting together the programs in our own office. The goal, obviously, is to have a system that looks seamless to families and if it causes a little bit of trouble for bureaucrats, that's OK. We can cope with that.

Many States have been very successful in pulling their programs together and operating them in a seamless way so that you use funds from one program to fill in and so on, even under the current statutory framework which is a little bit complicated. I think if we can make progress on that through the administration and at the State and Federal level it will enable us to use our dollars better, and most importantly is the potential effect it has on continuity of care.

We did a bunch of hearings last year as part of the welfare reform development process and heard from lots and lots of people, both welfare recipients and people who were trying to stay off the rolls, kind of what they needed. Some of the issues that came up had to do with the fact that, because of the way child care eligibility rules work and because of the fact that people's lives are so incredibly dynamic, they are in training for a while. They may be off for a while. They may need to work for a while. They are on and off of welfare. That sometimes there is not continuity for the care of these kids, and that can be disruptive both for the parent and the child.

If there is one problem that we need to solve it is that one so that we have some flexibility in the use of slots and in the use of funds. The block grant provides that. The IV–A Programs are less good about providing that. But I think that is one of the main things we need to work on.

Chairman WYDEN. So those are eligibility issues to make more standardized and more uniform those kinds of issues. I think that would be very welcome.

It really kind of gets me to my next question to you and that is the activities that you have under way in private business. This subcommittee really gets kind of two different ways. Child care has enormous implications for the private sector productivity. But also we know that lots of small businesses are now in the child care field. That's what they are. That's how they take home a wage at the end of the week.

We do — have discussed the issue that you mentioned how they make their way through this blizzard of forms and processing needs and sort them out. I am wondering what kind of efforts you have under way now with the private sector on child care issues.

Ms. BANE. Well, we are trying, as many States are, to build partnerships between Government and the providers and private businesses. We are trying to collect the activity, that really interesting activity goes on in local communities. We can only help spread the word and bring together ideas, and we are in the process of trying to collect a lot of information about the best things that are going on, and we're going to make it the focus of one of our major national conferences next year so that we'll indeed be able to work with a large number of States and grantees to help them improve that. We will, as always, have the Oregon people there to help us understand what the right way to do it is.

Chairman WYDEN. That will be a conference that specifically will be looking at your efforts with the private sector to try to get out information about innovation, discuss issues like standardizing eligibility requirements.

The Inspector General 2 weeks ago provided this subcommittee with a copy of a memo to you summarizing findings of a multiphase survey on criminal background checks for child care-givers.

In essence, what it said is that some of the employees in these centers have had pretty extensive criminal backgrounds, and the Inspector General found that even in States where background checks are required persons with some pretty extensive criminal histories are hired to take care of youngsters.

I think we would be interested in your thoughts, specifically about why this continues to be such a serious problem and what the Federal Government can do to assist in addressing it.

Ms. BANE. Well, I don't think we really know quite enough yet to make any firm statements. As you noted from the memo that the Inspector General sent me, it was a very preliminary study. It was not a survey. It wasn't a report. She looked at four States, at 50 or 100 cases, and in that small study it was quite disturbing. There is no question about that. Certainly raised issues for her and for us.

I think that we need to continue to gather the data in a more systematic way. I think that we also need to recognize that it has only been a very short time that the States — as part of a law that was passed last year, States were allowed to use criminal background checks and to use Federal funds to pay for those, and that's only been in place for a while.

I think we ought to see how that works. Our sense is that 35 States do now require criminal background checks for at least child care centers and 27 require it for family day care homes. Only 11 require it for relative care-givers or care-givers in children's homes. I think we need to see how that all plays itself out.

But, obviously, her findings were very disturbing. I think we need to continue to work with the States to find out how we can do it better and then to see if there is a need for anything more on the Federal level. We tend, of course, to be very cautious about Federal regulation of what is essentially a State activity. I think we need to follow this one out a little bit more before we take any larger steps.

Chairman WYDEN. Ms. Aronovitz, do you want to comment on that?

Ms. ARONOVITZ. Well, we read the study. We read the follow-up to the original study when the IG testified and we were there. But we've not studied this issue.

We do think that the National Child Protection Act of 1993, which was implemented last December — we haven't studied its implementation, but we do know from the IG report that they remain concerned about its slow implementation and some of the implementation problems that States are having.

The biggest concern they had was that States — all States do not have to report information on child abuse crimes. But there was also some other interesting preliminary findings that deal with obtaining disposition data. Because you can't really make decisions on employment, whether or not you are going to employ a provider, unless you have the final disposition. It gets very complicated when you are dealing with more than one State, and some of their cases did that.

There are some other preliminary findings. One of the things that the IG said in this memo, I think, was that there should be a coordinated body of Ms. Bane's office and States and advocacy groups to develop guidelines for using the National Criminal History Background Checks System, which is a system that States are now allowed to access with Federal funds to try to make this law happen or make this process happen.

We don't see any problem with that at all, and it would be interesting to know a little bit more about what might come up. But I think it's still too early in the implementation of the act to really know how well this ultimately will work and how well it will help States.

Chairman WYDEN. My sense is that is something that ought to be looked at. Because sensible guidelines in that area could really have two valuable purposes. You could make sure that you were in a position to weed out people with extensive criminal backgrounds, and, at the same time, if someone has been falsely accused or something like that you would find it out.

Ms. Elliot, what's your sense? Is there anything else that we should be doing in our State specifically on this very serious matter of trying to make sure that criminals aren't spending their day with Oregon youngsters?

Ms. ELLIOT. I don't think there is anything to add. I think that there really is a very difficult kind of a question from a public policy point of view. It's tremendously expensive.

When I look at the actual numbers and the fact that no criminal record check system really gets the people who do do harm to kids — because what we know is that they don't show up on the system until they have already done harm to kids, and, unfortunately, the first time is the one we find out about.

So it's a very expensive system. I think it can give parents a false sense of security about their children's well-being. We know how much we can do with small investments in terms of consumer education and technical assistance.

It's kind of like Tevya in Fiddler on the one hand. But, on the other hand, as a public administrator I don't want to give one public dollar to a known felon to take care of a child.

So I look at that whole piece. That's why I think it does need to be, if you will, an eclectic group of perspectives that weigh it out because there are resource issues but there are tremendous kind of——

Chairman WYDEN. Are you, as Oregon's point person on this, interested in this Inspector General recommendation that Ms. Aronovitz just discussed to improve access to that national program?

Ms. ELLIOT. Yes, it's certainly an area that we are looking at. We just began. We got authority in the last legislative session to do FBI record checks on child care facilities. It's discretionary. We don't have to do it. We're looking at exactly that issue in terms of where we move into that area, under what circumstances and how we do it. So, I'm very interested in the topic.

Chairman WYDEN. And your sense would be that having Oregon secure access into that program would be pretty helpful and cost-effective?

Ms. ELLIOT. I think so, but that's not an area that I have got that kind of knowledge on.

Chairman WYDEN. The other question I wanted to — a couple of others I wanted to ask you, Ms. Bane, dealt with the Federal Government's role in nutrition. My expertise here is more anecdotal. I've got a 5-year-old and a 10-year-old, and I see what happens if they don't eat lunch or something like that. My sense is that right up on top of the list what is important in child care is that kids get at least one good nutritious meal a day.

How close is the current child care system coming to achieving that goal — every youngster in the system gets at least one good nutritious meal a day?

Ms. BANE. Unfortunately, I'm not sure I know.

The main Federal program that's involved here is, as you know, a Department of Agriculture program, the Child Care Feeding Program, which does provide a lot of Federal money to homes. The information I've got is that it's over 100,000 family day care homes, for example, receive funds under the Child Care Feeding Program. They can be reimbursed up to three meals a day depending on how long the kids are there. It's a program that is very, very important to family child care, and it is used quite widespread. It's hard to know what proportion that number is since we don't know exactly how many family day care homes there are.

One of the benefits, obviously, for a family day care home to come into the system is that as they come into the system and to be registered they become eligible to participate in this program, which is an important one and is, I think, bringing many people in.

Chairman WYDEN. Is there anything else that your agency and the Federal Government might do in this area that Congress ought to be looking at?

Ms. BANE. In the area of nutrition? We're trying to work with the Department of Agriculture, obviously, to make sure that the information about the program gets out to all child care providers. I think in some ways that is one of the most important things that we could do.

I think that the sharing of information, the emphasis on nutrition — I think the new nutrition labeling guidelines will probably help for people to be able to understand what they ought to be providing to children in terms of nutrition. So, I think there are a number of things that we can do on the education side.

Ms. ARONOVITZ. We were very impressed with what we saw in this program, not only in terms of the actual subsidies given to family day care providers for the meals but also in the support and ancillary activities that went along with participating in this program.

You had sponsors who enroll groups of providers, and these are providers who do register. Not only do the providers learn about how to prepare or how to plan nutritious meals, but they also get quarterly training. They are helped with the paperwork. They also get home visits, which their plans and their activities are monitored. There's a lot of discussion not just about nutrition but also health and safety that providers learn from being part of this network or part of this program.

Also, the money in this program is not insignificant. We figured that a family child care provider with five children who are receiving a subsidy for three meals — and that's the children who have to be there all day — could receive up to about $300 a month in this program. That could be the amount of money that helps that family child care provider stay viable.

One thing that's interesting that we found to be very positive is that in the reauthorization of the National School Lunch Program, which is entitled Healthy Meals for Healthy Americans of 1994 — that's the reauthorization act — this particular food program is part of that act. The money will now — some of the money will now be able to be used to recruit unlicensed family child care providers, and the sponsors will be able to then prepare these family day care providers to be registered. So, you wouldn't have to have been accomplished already to be in the program. We think that's a step in the right direction.

Ms. ELLIOT. I think you said it.

Chairman WYDEN. Let me ask just one last question of you, Ms. Bane, as you know, again in the debate in the Congress one school of thought is that the Federal Government ought to simply back off, except in the area of something like tax deductibility for parents for child care costs. Without getting into all of these specific bills and the like, what are the ramifications for some of the issues related to quality and access as described by Ms. Aronovitz?

Ms. BANE. I think that over the time that the Federal Government has been a partner with States and localities in child care through the IV–A Programs and the block grants and so on we have been able to provide leadership and do work with others to genuinely improve the child care system. So, I think that the Federal Government has played an important role both in providing funds and in providing some leadership. Obviously, if we didn't have the partner, much of that would be lost. I think there will be a healthy debate about some of these issues over the coming months.

Chairman WYDEN. Ms. Elliot, what do you think? If the Federal Government's role is reconfigured so that the major thing that the Federal Government is doing is something along the lines of tax deductibility for child care costs for parents, what are the ramifications for some of the kind of quality and access initiatives that are under way between you and the Federal Government with respect to developing these models that could be used elsewhere?

Ms. ELLIOT. Well, it really speaks to the piece that I read under the market and the limitations of the free market in terms of being able to do everything that needs to happen.

If we look at 185,000 kids in Oregon who were in market child care and we then take that into 185,000 households and some type of a tax credit that goes back — of course, there is tax credits already in terms of their dependent care expenses. But if we put the resources that we currently have out through some kind of tax credit system what you have got is this large kind of amorphous system of parents over here and a provider system over here, which in Oregon we estimate is somewhere around 38,000 providers, family providers, day care center staff and whatever. How do you ever kind of coalesce the kind of critical mass of resources that can then come to bear in terms of key points in the overall system to be able to move it forward?

Because it isn't just an issue of money in the pocket of a particular household. If we had a system where all parents could somehow get together and say I'm going to take my $100 and you take your $100 and a thousand of us are going to get together and we're going to have $10,000 or whatever that is and then we can do something — but that isn't how this kind of consumer-choice-driven system operates in this country. I think that's one of the biggest problems around.

I think the problem is, if you will, any single strategy kind of an approach — I think we really thought at one time there was some magic bullet, a silver bullet that was going to come forward and solve this. That is the whole piece that we have done in Oregon in terms of saying there is a large menu of strategies that we need to pursue, and we need to use the best strategy where you can.

So we've used tax credits with employers. I think that is very effective. But in other areas tax credits are not the best strategies, and that is where we need to have Government funds going in to target those resources. That is in some way the reopening of the Act for Better Child Care debate of 5 years ago in terms of should we put it all into tax credits in parents's pockets or into the infrastructure?

The genius of the child care development block grant as a piece of legislation is that it really did craft a compromise that pulled those perspectives together into one program and said work it out. It's really been a remarkable piece of legislation, I think.

Chairman WYDEN. Let me move on now and ask some questions of Ms. Aronovitz. Ms. Elliot, we will probably have one or two for you as we go.

Ms. Aronovitz, what kind of growth is GAO predicting for home-based child care? Is there any kind of quantification that you can do there?

Ms. ARONOVITZ. I think it's very difficult to really know. We don't have any numbers. We don't feel we have any good numbers at all. A lot of it depends on the particular provisions of health reform.

The Center for Law and Social Policy about 6 or 8 months ago, when the administration's proposal on welfare reform was out, at that time, they estimated, based on admittedly very soft data, that you'd need 450,000 additional slots. It's based on a whole set of assumptions.

But I think a better answer would really say that any proposal that's going to target teen moms will increase the demand most rapidly. The younger recipients are the ones with the smaller children and the ones that are most needy right away.

But I think it's very difficult to be more specific than that until we know a lot more about specifically who will be targeted and what some of the other reform provisions will be, and then it will still be difficult to know.

Chairman WYDEN. I wanted to ask you as well a question about the role of the private sector. You in the report note that private dollars have funded a variety of health education and training initiatives within the child care sector. But you also noted that private sector funding, based on your analysis, was often very limited to seed funding kinds of programs and dollars that would be available only for a fairly short period of time.

What are the implications, particularly for low income, in communities when those kind of private sector seed funding kind of projects run out? What does your research tell you there?

Ms. ARONOVITZ. I think that in some cases we found that some of the initiatives that we were very impressed with were able at some later point to develop separate fund-raising initiatives on their own that would perpetuate those programs. So, there were two in particular, the California Child Care Initiative and the Oregon Child Development Fund, which came from model programs from the California Child Care Initiative. They were both able to kind of be self-perpetuating.

But in very many cases services do get curtailed. There is no doubt about it.

I think that communities, if they wanted to, could use some of the block grant money, but then again there are serious choices they have to make about how to use very precious dollars. But I think the real answer is that programs do become vulnerable when private seed money or the limited time for the grant is terminated.

Chairman WYDEN. Let me move on to you, Ms. Elliot, and ask you just a couple of additional questions.

With respect to choice in Oregon, in particular, how would you describe the situation for Oregon parents in terms of having access to a wide variety of choices in child care?

Ms. ELLIOT. Well, it's getting better, and it's not good enough. I mean, I think that, as you know, we have a benchmark around the accessible child care, and that's our way of trying to deal with that issue of choice. That, essentially, our goal is to have what we call an identifiable, visible child care slot for every four children. We don't know if that's absolutely right until we get there. But in the areas where we're close to that benchmark, it seems that there is a pretty good match between supply and demand.

But just because there is an overall match between slots, supply and demand, choice has a variety of factors that goes into it. Affordability impacts choice, in that the lower the family's income the more restricted their choices are in terms of what they need and in terms of what they can have.

The other piece is the demands of the workplace and the whole issue of when you work for Target — I don't want to pick Target out as an employer. It just came to mind. They're Dayton-Hudson, so they have actually put a pretty good investment into child care.

But when you work at a retail operation like Target and you're working 22, 23 hours a week and next week your employer says I need you for 35, then how do you find child care that meets that? Maybe those 35 hours are from 3 in the evening to 10 at night because it's Christmas season.

So that the straight choice issue we're making some progress on through our supply development initiatives, but I don't know. Parents who have $70,000, $80,000, or $90,000 a year incomes still struggle with the problems of finding appropriate care for their child.

So I think we're working in the right direction. I think we have some ideas of how to get going, but we have a long ways to go because the multiplicity, as I said, in terms of, again, the quality-availability-affordability trilemma that we talk about in child care.

Chairman **WYDEN**. One other area is one I might want to get your reaction to, Ms. Bane — and I hear it from child care providers, and I would think that the home-based providers would be especially concerned about and that is legal liability, the problems associated with some of the legal costs having to do with caring for youngsters.

Are there steps under way to see if there are going to be improvements in the way those issues are handled and the costs held down? Because we know that that gets passed all the way through. Your reaction first, Ms. Bane?

Ms. **BANE**. I actually haven't heard a lot about that issue in the last couple of years.

When I was commissioner in New York there was a flurry about that issue, and people were concerned about it. I think what happened is that cooperatives would work out its own, but it seems not, at least in my experience, to be a huge issue at this point.

I think that the networks, cooperation, the support to pool liability is obviously the way that people are solving this problem, and we need to keep working with them to do that.

What's your experience here?

Ms. **ELLIOT**. Well, I think I have kind of the same reaction, but I also know that it remains a problem. I think there's a couple of pieces with it.

One of it speaks to this issue of intentionality in how people operate their business. Than there's a problem with family child care providers being covered under their homeowners insurance policy, getting homeowners insurance dropped because they are operating a family child care business out of their home, even though it is legal. Some companies will exempt them if they take less than three kids.

But we're all talking about a system where we're trying to help providers operate successful small businesses and take somewhere in that area of four to seven or somewhere in that range. Then when they move into that range they are not fish nor fowl. They are still a family business, but they can't access affordable child care from the industry because the industry is not oriented in that way.

So I think it does still remain a problem for family child care, and I think some of the things we're doing will help to move it along.

But it still comes down to an issue — I think part of it being risk management. The industry is driven by risk management. When they look at an unregulated field without any standards of who's a competent manager of the business kind of thing, they look at this and say, sure, we'll insure you but, it's going to cost you $500 a month. I don't think it's that high, but it's pretty high.

Then you look at an undercapitalized, underfunded industry where providers are eking out a living. A $300 subsidy from the USDA food program can be a tipping factor of whether they make it or not. They can't pass those costs on to parents.

It is a problem, and I think that the reason we don't hear about it is that all of us have realized that the solutions are not going to come until we take care of some of these base kinds of issues in the field and then we can bring it to the table with a different perspective.

I think the industry needs to learn more about child care because I think that is part of what we are dealing with. We have had a relatively small arena of these issues. That's why I welcomed this subcommittee's attention to this issue. This is not a human resources subcommittee. This is a business subcommittee. We're beginning to say this is everybody's concern.

Because I think that if the industry, the insurance industry as a whole, understood the industry of child care better then they might be making better industry-based decisions. So, we've got to keep reaching out. But I think that what we found in Oregon is that a lot of the issues center around center care and those seem to be subsiding, but I think it really does remain an issue for family child care.

Chairman WYDEN. My concern would be — you said we don't know a whole lot about 50,000 plus home-based providers in the State of Oregon. Oregon has more oversight than the vast majority of States. So, you then say to yourself, you don't know much about 50,000 in Oregon; who knows what the situation may be elsewhere? And the liability insurance if a youngster breaks a leg, something like that, that is a real question whether they can get health care and also can improve the quality of the facilities.

Some of them may be coming in to do some checking before they write insurance policies. I think this is an area we maybe will want to continue our discussions with your office, Ms. Bane, and you as well, Ms. Aronovitz, because I suspect that we don't know a lot of about what is going on out there. There ought to be more of a safety net than to wait for kids breaking their leg in an unregulated facility.

All of you have been an excellent panel. We've had to make a round trip of 6,000 miles, and I want you to get off to the airways before the weekend. It's been very, very helpful.

We appreciate the work that the administration is doing with the subcommittee on this. Mrs. Aronovitz, our commendations to the GAO. To our long-time friend of this subcommittee, Janis Elliot, thank you for your work.

Do any of you want to add anything further?

You are excused with our thanks.

Our next panel — Ms. Bobbie Weber chairs the Department of Family Resources, Linn-Benton Community College in Albany; Jeanise Suihkonen — I hope I am not being too — Suihkonen?

Ms. SUIHKONEN. Right.

Chairman WYDEN. My apologies for bungling that. Ms. Margaret Ragan.

If the three of you will come forward. It is the practice of this subcommittee to swear all the witnesses. Do any of you three have any objection to being sworn as witnesses? Please rise and raise your right hand.

[Witnesses sworn.]

Chairman WYDEN. We are going to make your prepared statements a part of our hearing record in their entirety. So, if you could take 5 minutes or so and summarize the major concerns that you have, and then we will have some time for questions.

Why don't we start with you, Ms. Weber?

TESTIMONY OF BOBBIE WEBER, CHAIR, DEPARTMENT OF FAMILY RESOURCES, LINN-BENTON COMMUNITY COLLEGE, ALBANY, OREGON

Ms. WEBER. Mr. Chairman, I am Bobbie Weber, and I'd like to talk a little bit, because I don't think my title is descriptive of the perspectives I'm going to bring. I'm chair of Family Resources at Linn-Benton Community College. That's one of the original Mervyn's sites in Oregon. It was a Statewide initiative. So, I bring that perspective.

We also house one of the State's child care resource and referral agencies, and so I also bring that perspective. I'm the President of the National Association of Child Care Resource and Referral Agencies, and so I bring the national perspective.

Chairman WYDEN. Multiple hats.

Ms. WEBER. Right. I thought some of the comments would make more sense if I referred to that at the beginning.

I will share with you some of Oregon's story, and also I would like to speak specifically in a little bit more detail to the issues that we see coming with welfare reform.

Oregon's been a leader, as has been noted many times this morning, in State and national efforts to improve the quality of child care. In my written testimony I detail the numerous initiatives to improve quality in which we have brought both the public and private sectors into partnerships involving the local, State and, many times, national funders. We have — despite a very small corporate sector in Oregon, we've succeeded in bringing significant national corporate dollars in, I think largely due to our creativity and initiative.

We do know how to improve quality in child care and specifically quality in family child care. The research on what the status of it is right now and what we need to do to improve it, I think, is very strong, certainly strong enough for policy.

We know that there's a certain urgency that the findings from the Galinsky study and found in other places and interestingly enough of what is found in studies of center care, that only 12 percent of the care being given our children is good for them and that a third of it is actually harmful.

We know that in that 12 percent that's good for them there are a number of provider behaviors which cluster together and form predictors. So, while it's true that we don't know how to measure someone being warm and nurturing, we do know what's going to predict that the provider is warm, is nurturing and, even more significantly, is going to predict that the child comes through the system with strong language sills, social skills, the ability to reason, the ability to use his body effectively and appropriately. It's those kinds of behaviors that the initiatives that Oregon has put in place were designed to increase.

So in the last conversation that the three prior witnesses were going through they were talking about what we can do about quality in a nonmanaged, market-driven system. As Janis and Assistant Secretary Banes were pointing out, predominantly the money is coming in in individual provider by provider by provider, from individual families who use their services.

Where do you get the funds for the systems pieces that lead to the predictors of positive behavior? Because predictors of quality are providers joining associations, getting support from their child care resource and referral agencies, getting regulated, participating in the USDA Food Program.

So there has to be — and that would be a theme throughout — there has to be this dual system that we had modeled in the CCDBG, that there is a public role that needs to match the private role in the improvement of child care.

Because I think it's time to say we have a crisis. It's not good enough for only 12 percent of the care to be good for children.

Just a brief — because it's spelled out in the testimony, I'll briefly go through some of the things Oregon's done starting with 1988 when we got the Mervyn's initiative.

We were one of the first sites in the Nation. It later went on to 35 other sites, but Oregon was one of the first three. It was a three-pronged effort: Training of family child care providers that Jean is going to talk about; accreditation, getting providers to high standards of quality; and the very important piece of training parents through consumer education so that they could identify and choose the quality provider.

Those continue to be built into Oregon system. Family to Family has gone on in the Oregon system to become part of a multifunded family child care provider and training system that uses resources from community colleges, which are legitimate, public dollars that should be spent on this sector and that in most States are not. So, that's an area I think the committee and other people could be looking at. That also continues to use private dollars and local community dollars.

The Child Care Aware campaign continues to be the piece that targets parent education, and that also is still being carried out. That one still primarily through private dollars but some pretty entrepreneurial ways to work with Mervyn's Dayton-Hudson to bring in private dollars.

In 1989, the Ford Foundation came. The Oregon Child Care Initiative, which was a replication of the California Child Care Initiative, was actually Ford Foundation dollars. This was one of the most exciting use of private dollars to leverage public dollars.

What Ford said to the State of Oregon was, you need a child care resource and referral system if you're going to do anything about the quality of child care. We'll spend money here if you will build the system. So, the 1989 legislature did build a Statewide system of child care resource and referral.

On the private side, the Oregon Child Development Fund was created within the Oregon Community Foundation, and they continue to bring in dollars to train family child care providers, and we continue to use this system of child care resource and referral and community colleges as the Statewide delivery system that works with the provider associations.

I think it's one of the secrets of success is we don't give training to providers but with them. We are now getting AT&T money to improve quality through equipment. We are now getting other sources of dollars in forging the link. So, Oregon has really succeeded in doing that and building them into our system every step of the way, although that continues to be a challenge, to institutionalize these ideas when private funders bring them in.

I want to talk a little bit about subsidies and what Oregon has done in welfare reform because our welfare reform efforts continue to be successful. Despite significant in-migration, the actual numbers of persons on AFDC in real numbers goes down.

As Steven Minnick from Adult and Family Services was quoted this week in the article on the Oregon Option, pointing out what has strongly been this State's philosophy, that it's much better to put the money into child care than it is to continue to increase the AFDC rolls. Actually, Oregon benchmarks those two numbers right next to each other because we perceive the linkage to be that strong.

More importantly though, in terms of child care, the Adult and Family Services looked into the community way back in the late 1980's, as soon as they started building what we called here new jobs, before we participated in the Federal. They came to the local communities and said we need to plan. Just as you're saying this next thrust of welfare reform is going to bring all of these children into the system, AFS said we're bringing all of these children into the system. Can it handle it? What's there? What's the quality like?

They came and actually participated in local planning throughout the State. When CCDBG was passed in 1990, AFS was at the table planning with us so that we would be serving all families.

In 1991, AFS planned a partnership with the local child care resource and referral and developed four pilots that were then, 1993, moved into a Statewide partnership. The important part here is AFS didn't say, just go find child care to low-income families. What they said is, we're a partner in this. We're a partner with you, and we're a partner with the local community, and through the child care resource and referral agencies we're going to build the supply. We're going to work on the quality, and we're going to help the families get the education they need to look at that.

My own personal experience has been as a State partner and a local partner with AFS and the JOBS Program. I will be happy to answer your questions and tell stories about what the difference is between just telling somebody to go find child care and actually building in the structures that enable them to do it successfully. That is a big part of why Oregon is successful and why it is working, that families are getting off the welfare. But they are getting the kinds of help that makes sense.

The issues that we find faced by the families, especially the adult and family service clientele that we work closely with, a very serious lack of knowledge about how child care works. Not a clue what child care is. Don't even know that there is such a thing as a family child care provider or what a center would do or what it would cost. So, just never having had any experience and just an absolute lack of information. A belief that they have no options.

This has been mirrored in national studies over and over again. They believe they have to leave their children with anybody, their brother who uses drugs, their sister who they know doesn't pay any attention to the kids, because they didn't know there were any other options out there.

Also if they have ever heard of child care what they tend to have heard about is about the child abuse scares. So, what we hear families saying a lot is that I don't use child care because child care is not safe. But that is lack of knowledge about how to select it and how to identify quality, how to manage it.

Those kinds of barriers are very real. They are as real as the other barriers to employment. Because the kinds of informal arrangements tend to fall apart over and over again, making people lose jobs, so that these invisible supports are very significant and important.

I think some real, applicable lessons for the Federal Government — there need to be really options for families. The amount and quality of the existing supply is a serious issue. We do not have good enough care. That means that funding for child care for the working poor and for AFDC families is critical, that we can't pass welfare reform that doesn't fund a child care component, that the quality set-aside cannot be limited only to CCDBG. That when we spend money on actually getting people into care, we also have to worry about the part that Janis was talking about, the provider associations, the provider training, the food programs, the pieces that we know are predictors of quality.

Parents need consumer education and linkages that Oregon is giving families through their child care resource and referral. That parents need to be protected from unsafe care, that basic regulation lays a foundation for quality, and that community, States and Federal Government need to know if they of making a difference or not, meaning that we have to have a few pieces of data that we collect consistently within the States and between the States that we can then benchmark whether it's making any difference or not.

Some of the broader lessons that we've learned, not just to do with welfare reform that I want to go through briefly, and some of them echo things you have heard already. No one sector can fix this problem by itself. The Federal and State government need to partner with parents, with the corporate sector, with the local communities, child care resource and referral and other providers, and that policy simply has to be made that way.

Getting corporate and parent perspectives at the policy table may be the greatest challenge, but I don't think we're going to fix the problem until we do. The State needs a shared vision. I think you heard that from Janis, and it was echoed by other witnesses, that if everybody's trying to build a different airplane, it's unlikely that anybody's going to fly.

Oregon has succeeded through hard work and getting to a shared vision, and I think that is a model and is something that needs to be replicated.

Leveraging can lead to the institutionalization of needed services, and this is an idea that I think needs to be paid a great deal of attention to. Right now, the national foundations are very concerned about child care, but they don't intend to spend their dollars there forever or for very long.

It's not going to do America's families any good to have found out that we can do it if we then do not find ways to ensure that those essential services continue to exist. We need the leveraging of public dollars to make the public-private system work, and we need to do it in planned, thoughtful ways.

Subsidy systems have the power to impact quality in ways that are far greater. Janis was very specific about that. All subsidy programs need to take into account their impact on quality and think about ways to use them for improving quality. High levels of turnover continue to threaten the well-being of children, and in Oregon we have turnover rates of 30 to 50 percent. Turnover is closely tied to wages. We're not going to fix this problem without looking at that base kind of issue.

I will close with our absolute belief that the Federal Government is a key player but only one of the essential players that needs to work with the States and communities in the public and private sector. That some of the concerns we have are that even though we know what to do that will make a difference in quality we still don't have it in place. Even though we know what are the predictors of quality we still have a long way to go to ensure that those are the providers that families are choosing. That the system pieces are critical and that the dreamed of partnership needs to include both ways that families can purchase care in this market system but also that the system can build the amount and the quality of care that America needs for its children.

Thank you.

Chairman WYDEN. Very well said. Excellent testimony.

[Ms. Weber's statement may be found in the appendix.]

Chairman WYDEN. Ms. Suihkonen. Welcome.

TESTIMONY OF JEANISE SUIHKONEN, SALEM, OREGON

Ms. SUIHKONEN. Thank you. I'm Jeannie Suihkonen, and I am a 35-year-old family child care provider living in Salem.

As long as I can remember I have looked forward to being a parent, and my husband and I are raising two children, an 8-year-old girl and a 5-year-old boy. It is as rewarding and as magnificent as I always thought it would be, while being more challenging and frustrating that I imagined.

Prior to my work in family child care I had a career in dental assisting for 8 years. in 1987, when my daughter was 1, I decided to stay home, but I needed an income. Family child care seemed like the perfect blend of the two.

I provided child care for 1 year, and I quit. I was miserable. I had no support for my work as a family child care provider and went back to dental assisting.

In 1989, my second child was born, and I had met a neighbor who was doing family child care, and she gave me some information on professional support groups for providers. I really wanted to be with my children, so I decided to try family child care again.

I joined Salem Home Child Care Association and learned about a new class being offered at our local community college for family child care providers called Family to Family. This class was packed with resources and information, exactly the piece that was missing from my success.

I learned how to write business contracts, work together with parents, where to find first aid and CPR classes and why it was important for me to take them. I also received information on child care development, planned activities, children's environment, guiding children, keeping business records, health and nutrition information, community resources and much more.

I took this new awareness home and put it to work immediately. These classes began a commitment for me to grow professionally. I strongly believe that if more training opportunities like Family to Family were available at an affordable rate, especially for people just starting out in this business, by far it would increase the quality of family child care, job commitment, self-esteem of family child care providers and contribute directly to the length of a provider continuing in this business.

I know that providers who have a sense of commitment and are intentional in their approach are more likely to provide quality child care. For those who don't receive the missing piece for their business we will never know the positive contribution that might have been.

In 1993, I was elected co-president of Salem Home Child Care Association. I'm now chairperson for an Oregon Association for the Education of Young Children task force to begin a family child care network in the State of Oregon. Though the network is in the infancy stages, we are hoping that this will be a direct line of communication for information exchange from the State to family child care providers and vice versa.

I feel that some great things are happening in Oregon for family child care, and it can continue to grow and will only improve Oregon now and in the future. Awareness brings knowledge, knowledge is education, from education comes professionalism, and professionalism brings quality. This is something we all want for our children.

If we want quality family child care, we have to continue to offer education specifically designed for family child care providers and offered at hours that family child care providers can attend without interfering with business hours and at an affordable rate.

Taking Family to Family classes was the beginning of professionalism for me, and I know that I would not still be in this business if the information was not available to me.

I have been successfully providing child care for 5 years now, and I've received my National Family Child Care Child Development Associates Accreditation in October, 1992. I am committed to seeking training and new information regarding child development and quality family child care procedures. I will continue to do so as long as they are available to me.

Thank you.

Chairman WYDEN. Thank you. Very well said. I will have some questions in a moment.

[Ms. Suihkonen's statement may be found in the appendix.]

Chairman WYDEN. Ms. Ragan, welcome.

TESTIMONY OF MARGARET RAGAN, PORTLAND, OREGON

Ms. RAGAN. Thank you. I am Margaret Ragan. When my first and only child, a daughter, was 6 weeks old I returned to work full time. I worked for a company that paid well, offered paid medical benefits and was paying for my college education.

My husband also worked full time. We spent weeks looking for a home child care provider, and articles we had read recommended a home environment for infants. We found the individual we felt comfortable with. She was registered with the State and was signed up for the USDA food program and said she was certified in CPR and first aid. We called references which she provided, and they were all good or great recommendations. We asked questions that were provided to us by the local referral agencies. We felt that we had covered all of our bases.

When my daughter was 9 months old she wasn't crying or walking yet. She wasn't mobile at all. I drove to the provider's home to pick her up.

Chairman WYDEN. You're doing great. Take your time. We've got all the time in the world.

Ms. RAGAN. I drove to the provider's home to pick her up in September of 1992. When I arrived, my daughter had been fussing and was really uncomfortable. The provider told me that he bumped her head around noon that day, and she couldn't find a bump on her head but had iced it anyhow.

I carried my daughter to the car and tried to put her in the car seat, and she started crying really hard. So, I took her back out, and I tried to put her back in again, and she started crying even louder. So, I asked one of the other parents to drive me home. On the way home I lifted up her right leg, and she started crying really hard, and I realized she didn't have a bump on her head, she had something wrong with her leg.

So when I got home I took her to the hospital right away, and we found out that she had a broken femur. It was a spiral fracture, which is a twisting break. This is the cast. She sat at that woman's house for 5 hours that day, and nobody recognized that this was the problem.

They put that cast on her, and she was hospitalized, and she was given Demerol every 2 hours through the night before she could finally come home. The police did an investigation. There were no witnesses, except the woman's family. They were sorry, but they couldn't prove that it was anything more than an accident. They didn't have liability insurance, so we hired an attorney to pay for the medical expenses.

In a worst-case scenario, one leg could have been longer than the other. In another scenario — this was the wrong cast. It should have been a full body cast from under her armpits down her whole body. The wrong cast was put on, but she was OK.

I've spent the last 2 years at home with her, and I have provided home child care to other children, because I knew I could keep them safe.

Now she's able to talk, and she can tell me what's going on in her life. I'm not doing child care at home any more. I am working outside. She goes to preschool, and I'm comfortable with that. I feel OK with that.

But the problem with child care is that there's no one to check these homes, and there's no competency testing. You can't tell the difference between a bump on the head and a broken leg?

We require people to have liability insurance on their car, but we don't require these people to carry a simple policy on their home insurance to cover something like this. That was the least of the problems. Our car is more important than children?

My liability insurance on my home child care costs me $130 a year for six children. That's a drop in the bucket. I wrote it off on my taxes. That's not an issue.

If you want to be a plumber in this State you have to be tested to fix somebody's pipes. If you want to sell a house as a real estate agent, you have to take a 5-hour exam. To be a home child care provider in this State you fill out a form, mail it in, let them fill check your criminal record, and, boom, you're registered. But we don't know if they know how to change a diaper.

That's all I have to say.

Chairman Wyden. Well, I don't think anybody could have said it any better. I really appreciate your coming. There is nothing harder and nothing more wrenching than talking about a situation that has impacted your family. I appreciate your coming.

[Ms. Ragan's statement may be found in the appendix.]

Chairman Wyden. The only thing I really want to ask is what is the message for Government on this? Put yourself on this side of the dais. You're where I'm sitting now. What should people be doing in Government?

Ms. Ragan. I want there to be a competency test for home child care providers. I want them to sit down and take a 2-hour examination that has scenarios. If this happens to a child, what would you do? Have them choose the correct answer? Have some kind of a test so that you know whether or not this person has ever even held a baby before? The forms they fill out now don't tell you that.

They have just now started requiring home child care providers to take a class on child abuse awareness. But if they haven't had first aid or CPR, that's not required. That's highly recommended. It's not required.

How can you recognize if a child has been injured by abuse if you haven't taken first aid? That's what I'd like to see. I'd like to see competency testing done and charge people. If people want a career at home, then have them pay for the exam. If you want to be a plumber, you have to pay for the license. Have them pay to do it.

I would be willing to pay that. If I want to stay home with my child until I feel comfortable putting her some place, I would be willing to pay the $100 to take the competency exam. I don't have to have a college education to pass it. I have enough experience. I could pass a competency exam. That's what I would like to see.

Chairman Wyden. Ms. Weber, you spend a lot of time working with people in training programs and the like. Do you find what Ms. Ragan's talking about is widespread and people don't know how to hold a baby or won't be able to see a serious injury on a youngster — like in your situation, I think you said for 5 hours.

Ms. Ragan. For 5 hours. From noon to 5:30, when I picked her up.

Chairman Wyden. Sitting there with a horrible injury and nobody recognized it. Is that the kind of thing that you see on a widespread basis, given your involvement in training programs and the like?

Ms. Weber. This provider had done all the things that were recommended in terms of getting regulated. I don't know — it didn't sound like she had any training. In response — so I don't know that I could — the scary part is that you can't give the parent an assurance.

In terms of what we see, we see a range of quality, but we see only a sector of the supply. We see the most visible. That means it's the people who are most likely to be doing the things that are predictors of quality.

Therefore, it's less likely that we would see the kinds of things in our training classes that Ms. Ragan saw or found in her personal experience.

But it raises a very serious issue of — for instance, we exempt in Oregon — we finally got the rules, but we exempted huge categories of people. So, we're not going to be capturing, even with the minimal kinds of safeguards, a significant portion of the supply.

So you hear many of the applicants saying that we need to require regulation with no exemption because of that. The Galinsky study is worrisome because what they found was that this huge percentage of informal providers who were caring for children to do parents a favor were giving far worse quality care than the providers who were in this other group that Janis referred to as intentional providers.

People who were making a decision to do care tend to do things like get regulated, get in the food program and get involved in working with child care resource and referral. They do this number of activities that forms predictors of quality.

The issue that I think is very serious is but what about the people we can't find or that don't choose to come forward, and yet huge numbers of Oregon's children or the Nation's children are in that care.

Chairman WYDEN. That's the more than 50,000 youngsters that Ms. Elliot was talking about?

Ms. WEBER. That's right. Nationally you get issues of welfare reform — this Federal Government through welfare reform is paying for some of that care and initiative. So, those issues are clearly there and very difficult to deal with.

Wonderful care exists in our community and awful care exists in our community. It's going to take a number of strategies to change that.

Chairman WYDEN. I didn't mean to interrupt you, but isn't the challenge to make sure that the good care is not in any way altered as a result of some kind of Government fiat but that there is enough oversight, enough scrutiny and enough of a watchdog role as to reduce the numbers of problems that Ms. Ragan had and other Oregon families?

Ms. WEBER. Regulation is a foundation. Some people are talking about a consumer right to protection in child care. Oregonians and the rest of the Nation don't have that because we're not providing that minimal level of protection for families that would decrease that number.

Chairman WYDEN. Ms. Suihkonen, what is your reaction to this as it relates to the Government's role in terms of working with these facilities so that there is a basic set of protections for the youngster, while at the same time not drowning the homes in bureaucratic regulations which just increases the cost of care and limits access?

Ms. **Suihkonen**. I envision a career lattice and different levels of training, experience, education and what have you and then making that information privy to the parents via the R&R's or what systems we have. Educating the parents also so that which they come into the home and begin an interview with the provider then the provider can say, I'm a level 3, and these are the things that I've achieved.

Of course that can't guarantee that an accident won't happen, but I think that it's a good way to set up a system that the providers will know where they stand, parents will know where the providers stand, and it's a communication device.

Chairman **Wyden**. I think it's an introductive idea, sort of a consumer's guide so that when a parent goes to the child care program they could know something about the way this provider has achieved a certain level of training and the like.

Do you think, though, that there needs to be a threshold like Ms. Ragan is talking about, a sort of competency test that is more than filling out a piece of paper?

Ms. **Suihkonen**. Personally, I'm in favor of inspection, and I'm in favor of requirements. I don't have a long list of how I think it should go, but I think that it's important to family child care that we do have some boundaries, that there are some requirements.

Chairman **Wyden**. I really don't have any more questions for this panel, but I want to tell you that as far as I'm concerned there is no more important task for this State than protecting kids. I mean, there cannot be an acceptable level of poor quality care, abuse, inadequate training of providers. There cannot be an acceptable level of those problems.

This is going to be, for our State, a huge challenge. We've got much more to do in terms of building links with private business. It is going to be even more challenging, given welfare reform, because you're going to have thousands of more families brought into the system.

But what this debate is all about is what Margaret Ragan just talked about. Parents and families should not have to fear in this State that they are playing Russian roulette with their youngsters when they drop that youngster off at a child care program. They should be able to be certain when they drop off a youngster that they are going to be in a program where the people who run it know something about health care, know something about good nutrition, know something about first aid, know something about the fundamentals of ensuring that our kids, the most precious part of Oregon, are going to be secure during the day.

So, I want to thank you. We're going to be anxious to work with you all — because you are on the frontlines — closely. The next few months, in particular, are going to be hectic. Welfare reform and these issues are going to be part of the first 100 days of the Congress. This isn't going to be one of these things where you have an election in November and then you start talking about something in June.

I tell you, by the way, I just don't think you can have successful welfare reform unless you improve access and quality to child care services. The two are inextricably linked. You cannot do one without the other. Given the fact that Margaret Ragan and other parents and other Oregon parents are talking about problems today, we've got a lot of work to do. There is no acceptable level of poor quality care for Oregon youngsters, abuse, poor training, that I'm willing to sit by and watch.

So I thank all three of you for an excellent presentation and really challenge the elected officials to get serious about making sure that our kids get a fair shake. Thank you.

Would you like to add anything further? I always like to give our witnesses the last word.

We thank you. The subcommitteee is adjourned.

[Whereupon, at 12:45 p.m., the subcommittee was adjourned, subject to the call of the chair.]

APPENDIX

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Regulation, Business
Opportunities and Technology, Committee on Small Business,
House of Representatives
Field Office Hearing in Portland, Oregon

For Release on Delivery
Expected at 10:00 a.m.
Friday, December 9, 1994

FAMILY CHILD CARE

Innovative Programs Promote Quality

Statement of Leslie G. Aronovitz, Associate Director
Income Security Issues
Health, Education, and Human Services Division

GAO/T-HEHS-95-43

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting me here today to discuss the ways in which children who are cared for by neighbors and friends--called family child care--can receive the highest quality care possible. As you know, our report[1] that you are releasing today discusses our findings about family child care initiatives nationwide that are working with providers to enhance the quality of care they give children. Family child care is a popular option for many families, especially low-income families, because it can be more flexible than child care in formal centers. Unlike many centers, family child care providers will care for infants and toddlers, and accommodate parents' nontraditional work and school hours.

Despite family child care's wide use, questions have been raised about the quality of care provided in these settings. Often, family child care providers do not have the money or time to attend professional development activities and are not linked to networks or support groups that can supply toys, other materials, and help when difficult situations arise. Quality in family child care is important, as it is in all child care settings, because it can contribute to children's later success in school and, in conjunction with other supports, may break the cycle of intergenerational poverty.

---

[1] Child Care: Promoting Quality in Family Child Care (GAO/HEHS-95-36, Dec. 7, 1994).

At your request, we identified public and private initiatives to enhance the quality of family child care, their sources of funding and the implications of our findings for welfare reform. In summary, there are 195 initiatives nationwide seeking to improve family child care quality. They are funded from a variety of public and private sources and many rely on more than one funding source. As you know, many welfare reform ideas are being discussed. Most of them involve plans that would significantly add to the number of welfare mothers required to participate in education, training, and work programs. This will likely increase the use of family child care and thus add to the urgency of enhancing the quality of this care. Today, I will discuss several innovative programs that work toward improving the quality of family child care in Oregon and around the country.

BACKGROUND

From 1976 to 1991, the number of single, women heads of household with children under age 6 receiving Assistance to Families with Dependent Children grew from about 900,000 women to over 1.7 million. These are the same women being targeted for mandatory participation in education, training, and work programs in an effort to make them financially independent of the welfare system. Their children need some form of care while the mothers participate in these programs.

Child care outside the home is provided in several different settings--formal centers (often in schools, churches, office buildings, and stand-alone centers), family child care homes, and in the homes of relatives. Family child care is offered usually by individuals unrelated to the children, in the caregiver's home, to a few children. The caregivers can be neighbors, friends, or persons previously unknown to the family.

The significance of quality child care, in whatever setting it occurs, to the healthy development of very young children and its impact well into adulthood have recently been underscored by new research. A 1994 study by the Carnegie Corporation of New York found that the cognitive, emotional, and social development of children, and their functioning from preschool through adulthood, "hinges to a significant extent on their experiences before the age of 3."[2] Other research has shown that quality child care can be particularly beneficial to economically disadvantaged children. Quality child care helps those children compensate for some of the environmental deficits in their lives--such as minimal parental education, linguistic isolation, and limited access to preventive health care. These deficits are ones that tend to increase a low-income child's risk of doing poorly in school and later in life.

---

[2] Starting Points: Meeting the Needs of Our Youngest Children (New York: Carnegie Corporation of New York, Apr. 1994), p. 6.

Despite the importance of quality child care in the early development of both poor and nonpoor children, experts believe that too often child care settings lack the elements associated with quality, such as well-trained providers; small groups and low child-to-staff ratios; low staff turnover; age-appropriate materials; and physical space that is safe and hazard free. Family child care providers in particular tend to be untrained, unregulated, and unconnected to professional groups that promote these elements. So quality is of special concern in these settings.

EFFORTS TO IMPROVE FAMILY CHILD CARE QUALITY

We found that many organizations sponsor activities that work with family child care providers to improve the quality of care they give to children. While their purposes, approaches, and methods of working with providers differ, all these initiatives have the overarching goal of supporting providers. These organizations generally focus on three approaches to fostering quality care: (1) support networks; (2) training, recruitment, and consumer education initiatives; and (3) health initiatives. Appendix I shows some of the key activities included in family child care quality improvement initiatives.

We found a variety of examples of these approaches in Oregon and in other states. A representative of one of them--the

Family-to-Family project--is testifying before you this morning. The Family-to-Family project, funded for 3 years, gave grants to communities in Oregon and across the country to establish training for child care providers, educate parents about choosing child care, and connect providers to professional associations to pursue their professional development.

On our site visits to 10 other initiatives, we visited the homes of some participating providers. We saw caregivers who were very enthusiastic about working with children; a great number and variety of toys, books, and playground equipment; and the excitement with which the providers talked about the new and continuing training opportunities they have because of their participation in the initiative.

For example, in Atlanta, we visited the homes of three providers who were participating in Save the Children's Neighborhood Child Care Network. These homes were well equipped with toys and educational material for the children. But the most interesting "toy" from our perspective, as well as the kids', was the computer each of the providers had for the children to use. The initiative had received the computers as a donation with a software package geared to helping older preschoolers learn to read. We saw confident 3- and 4-year-olds unintimidated by technology and rushing to be the first to use the software. Whether or not these children learn to read from the computer program, they will be better prepared to handle the technology that is becoming more prevalent in both our schools and workplaces.

In Oregon, we visited an initiative that was reforging ties between the public health and child care communities. This initiative is the American Public Health Association project being conducted in Hood River, Wasco, and Sherman counties. Given the large number of children being cared for in centers and in other people's homes--especially infants and toddlers whose immune systems have not fully matured and who are more prone to injuries--there has been much discussion over the urgent need for child care and public health to work more closely together.

This project is doing just that through two county health departments and a local resource and referral agency. A public health nurse makes home visits and consults with family child care providers over the telephone. She also distributes useful items that range from educational pamphlets to smoke detectors and safety latches. The day we visited, the nurse had just received a call from a family child care provider who did not know how to treat a child's pin worm infection. The nurse was going to visit the provider to explain a course of treatment and to examine the other children. Interestingly, the provider found out about the project through a training session sponsored by the local resource and referral agency. Public health support is so important because more and more children--especially low-income children--do not have easy access to preventive health care. Consequently, child care providers are having to deal with much more serious health problems of children in their care than just pin worm.

FUNDING FOR FAMILY CHILD CARE INITIATIVES

We found that funding for the 195 initiatives we identified comes from a combination of private, federal, state, and local sources. Appendix II lists these sources of funding. Several of the initiatives we visited were working with relatively small amounts of funding but were still able to provide an array of support services to providers. Project directors we spoke with believed that their support to providers made a significant difference in the care given to children.

Private dollars have played a major role in funding family child care initiatives. Private funding comes from foundations, endowments, businesses, charities, fundraising, and user fees. Our study found that over half of the initiatives we identified received private funding, and private money was the sole funding source for over 20 percent of them. However, private funds are frequently only "seed money" to launch a project for a short time.

In Oregon, an example of private sector involvement in supporting family child care is the Oregon Child Development Fund. The fund was created to support initiatives focused on family child care issues in the state. Because of its success, it has taken on a larger mission of tackling broader child care issues, such as training and retention of child care providers--that is, reducing staff turnover. The fund only solicits from the private sector and has raised over $1.5 million from businesses, foundations, and corporations for its family child care projects since 1990.

The federal government's role in child care has traditionally been that of helping parents pay for the cost of care, rather than one of improving the quality of care. However, our study found that the two federal programs used most frequently by initiatives to improve the quality of family child care were the Child Care and Development Block Grant (CCDBG) and the Child and Adult Care Food Program. Eighty of the family child care initiatives we identified used CCDBG to help finance their support activities, while 58 of them used the food program.

In fiscal year 1993, the federal government made available approximately $8 billion in child care funding through seven major federal programs. Of that amount, we estimate that approximately $156 million to $264 million was available[3] for quality improvement initiatives for all child care settings, including those we found that focused on family child care.

Finally, states and local governments also provide funding to support family child care quality initiatives. We found that 19 percent of the initiatives we identified had received state or local funding or both.

IMPLICATIONS FOR WELFARE REFORM

Most discussions about reforming the welfare system focus on requiring more welfare recipients to either work or attend education or training programs to help them acquire basic skills and become independent of welfare. As a result, the number of children needing child care--particularly very young children--is predicted to grow. Because family child care is the choice of a significant proportion of poor families, its use will grow, too.

---

[3] Since CCDBG requires states to spend at least 5 percent of their total CCDBG funds on quality improvement activities, we derived our minimum estimate by calculating 5 percent of the total CCDBG fiscal year 1993 obligation figure and adding $113 million for administrative costs for the Department of Agriculture's (USDA) food program in fiscal year 1993. (Administrative costs include the quality support activities, such as training and monitoring conducted by the program for family child care providers, as well as the administrative costs for centers.) However, states may spend up to an additional 12.5 percent of their total CCDBG funds on quality activities. Thus, we derived our maximum estimate by calculating 17.5 percent of total CCDBG funds spent on quality and added $113 million for the USDA food program.

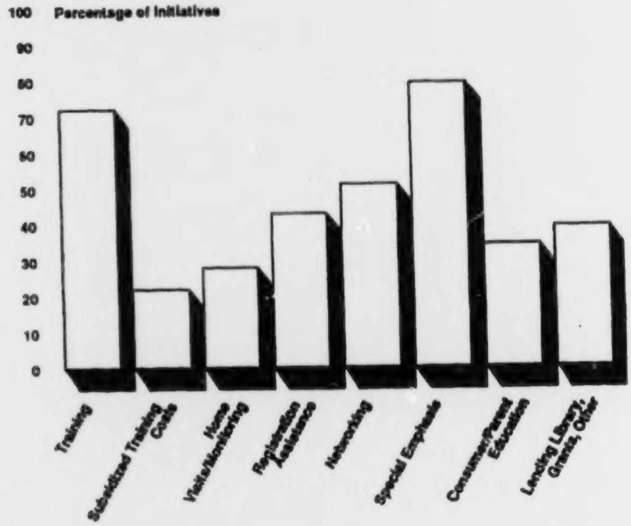
As we have stated, studies have shown that quality child care is critical to children's proper development. Thus, as the demand for family child care grows, so too will the need for this care to be of high quality. The initiatives discussed here today can provide us with valuable lessons about how to improve family child care quality.

- - - - -

This concludes my prepared statement. I would be happy to answer any questions you or other subcommittee members may have.

For more information on this testimony, please call Lynne Fender, Assistant Director, at 202-512-7229. Other major contributors included Janet Mascia, Senior Evaluator.

SERVICES PROVIDED BY FAMILY CHILD CARE QUALITY INITIATIVES



Note: "Special emphasis" means that the initiative focused on a particular population such as working with low-income providers or serving children with special needs.

Because initiatives provide multiple services, the percentages add to more than 100 percent.

FUNDING SOURCES USED BY FAMILY CHILD CARE QUALITY INITIATIVES

Total initiatives: 195

Source	Initiatives that received funds	Percentage of total initiatives
Federal		
Child Care and Development Block Grant	80	41
Child and Adult Care Food Program	58	30
Other	43	22
State	38	19
Local	38	19
Private	107	55
Private only	43	22

Note: Because initiatives had more than one funding source, column totals will exceed 195 initiatives and 100 percent.

(105586)

United States General Accounting Office

GAO

Report to the Chairman, Subcommittee
on Regulation, Business Opportunities,
and Technology, Committee on Small
Business, House of Representatives

December 1994

CHILD CARE

Promoting Quality in Family Child Care

Printed copies of this document will be available shortly.

GAO/HEHS-95-36

GAO

**United States
General Accounting Office
Washington, D.C. 20548**

Health, Education and Human Services Division

B-257209

December 7, 1994

The Honorable Ron Wyden
Chairman, Subcommittee on Regulation,
  Business Opportunities, and Technology
Committee on Small Business
House of Representatives

Dear Mr. Chairman:

During the last 20 years, the demand for child care has steadily increased. In that time, the percentage of working women with children under age 6 doubled from 30 percent in 1970 to 60 percent in 1991. Care outside of a child's home enables parents to work or attend school or job training to secure the economic well-being of their families. Among the primary child care arrangements parents use, family child care--care in the home of someone not related to the child--plays a significant role in meeting the child care needs of families, particularly those with very young children and those who are poor.

The demand for family child care is expected to grow given the welfare reform proposals that include education or job training requirements for more mothers of children receiving Aid to Families With Dependent Children (AFDC), particularly the younger mothers (who tend to have younger children). However, questions have been raised about the quality of the care provided in these settings. A recent study of family child care, which documented that a significant number of providers were giving inadequate care, has further highlighted these concerns. As a result, you asked us to (1) identify public and private initiatives to enhance the quality of family child care and determine how the initiatives are financed, (2) describe the federal role in supporting quality initiatives, and (3) discuss the implications of our findings for welfare reform.

RESULTS IN BRIEF

Many initiatives nationwide seek to improve family child care quality. These initiatives are financed both from public and private sources, and many receive funding from more than one source.

Federal support is provided through seven major funding streams that made approximately $8 billion available in fiscal year 1993. Most of this $8 billion went to subsidies to help parents pay for child care, but we estimate that approximately $156 million was available for efforts to improve the quality of care. Among the 195 family child care quality initiatives we identified, we found that two federal sources were used most often: the Child Care and Development Block Grant (CCDBG) administered by the Department of Health and Human Services (HHS) and the Child and Adult Care Food Program (the food program) administered by the Department of Agriculture (USDA).

Our site visits showed that initiatives use money from a variety of private and public sources in an array of approaches to enhancing the quality of family child care, including training providers; supplying them with equipment, educational materials, financial assistance, and other support; and linking them to resources and professional associations. For example, one Oregon program gives family care providers access to ongoing health promotion, protection, and education as well as home safety assessment tools and child safety items such as smoke alarms and socket plugs. Research shows that these kinds of activities are critical to enhancing the quality of care in all types of child care settings.

Research shows that quality child care is particularly important to poor children. Since the use of family child care is expected to grow given most welfare reform scenarios, the initiatives we identified can provide information on ways to improve quality in family child care settings.

BACKGROUND

Child Care Settings

Child care outside the home can take place in different settings: centers, family child care homes, and relatives' homes. Centers are usually large facilities that typically care for more than 13 children and are located in schools, churches, office buildings, and the like. In contrast, family child care is offered by individuals in their homes to a small number of children--usually fewer than six. These providers can be neighbors, friends, or someone families learn about through friends or advertisements.

Relative care is care provided by a person related to the child other than a parent.[1]

The flexibility of family child care makes it an attractive choice for parents. In contrast to most centers, family child care providers accept infants and young toddlers. Approximately 23 percent of employed women use family child care for children between the ages of 1 and 2, while 20 percent of employed women use it for children under 1.[2]

Family child care providers also usually have longer hours, may provide weekend and evening care, and may accommodate the hours of parents working shifts. They are also more likely to offer part-time care. These features are important to many lesser skilled and lower paid employees who tend to work shifts or other untraditional schedules. Part-time care is useful for those in the type of job-training activities in which AFDC mothers participate. Hence, family child care is a frequent choice among low-income families. Between 18 and 20 percent of children under age 5 of poor, single, working mothers are in family child care.[3]

Elements of Quality Care

Whether provided in centers or in family child care settings, quality care is care that nurtures children in a stimulating environment, safe from harm. Research has documented the elements of care that are associated with quality. They include providers trained in areas such as early childhood development, nutrition, first aid, and child health; small groups and low child-to-staff ratios; low staff turnover; a variety of age-appropriate materials; space that is safe and free from hazards; and settings that are regulated. Experts believe that characteristics such as these are good predictors of whether quality care is being provided. While only a small proportion of the research conducted in this area has focused specifically on quality in family child care settings, researchers believe that the same characteristics apply to any setting.

---

[1] Sometimes, however, the line between relative care and family child care is blurred because relatives may care for unrelated children as well as related children in their homes.

[2] S. Hofferth, A. Brayfield, S. Deitch, and others, National Child Care Survey, 1990 (Washington, D.C.: Urban Institute Press, 1991), p. 50.

[3] S. Hofferth, A. Brayfield, S. Deitch, Caring for Children in Low-Income Families: A Substudy of the National Child Care Survey, 1990 (Washington, D.C.: Urban Institute Press, 1991), p. 23.

Importance of Quality Child Care

For many years, researchers have known that child care quality, regardless of the setting, is important to all aspects of children's development--physical, cognitive, emotional, and social. The quality of these settings in preschool years also has implications for children's development and success later in school. However, new research documents to an even greater degree that how individuals function from preschool through adulthood "hinges, to a significant extent, on their experiences *before* the age of three."[4]

Research has also shown that quality child care can be most beneficial to economically disadvantaged children. Factors associated with low-income families--minimal parental education, linguistic isolation, single-parenting--increase a child's risk of doing poorly in school. Quality child care settings can help poor children overcome some of the environmental deficits they experience.

Difficulties in Achieving Quality in Family Child Care

While family child care providers in the United States generally have low child-to-staff ratios, they work in isolation from others, are generally not trained in early childhood development, and tend to be unregulated. Hence, the quality in family child care is considered by experts to be quite variable. A study done by the Families and Work Institute, which found 35 percent of the family care providers in their sample were giving inadequate care, recently highlighted these concerns about quality.[5]

---

[4] *Starting Points: Meeting the Needs of Our Youngest Children* (New York: Carnegie Corporation of New York, Apr. 1994), p. 6.

[5] E. Galinsky, C. Howes, S. Kantos, and others, *The Study of Children in Family Child Care and Relative Care: Highlights of Findings* (New York: Families and Work Institute, 1994), p. 4.

Although family child care is used by many employed mothers with young children, states and localities generally do not regulate it as they do center care. One study estimated that approximately 82 to 90 percent of family child care is unregulated in the United States.[6] Hence, many family child care providers operate legally but do not have to meet any standards to protect the children's safety and health. Experts believe that meeting at least some minimal child care standards as a precondition to providing care is an important step in building quality into all child care settings.

If a family child care provider wants to become registered or licensed, the process can sometimes be intimidating and costly, especially relative to the low wages most providers earn. Incentives to become registered or licensed are few and providers may encounter barriers and be uncertain that they can charge parents higher fees if they meet requirements that help them provide higher quality of care.

Family child care providers also have difficulty getting the information and resources they need to run a successful business and to enhance the quality of care they provide. For instance, family child care providers may be unaware of child care training available in their communities because they usually are not part of a professional organization or linked to other networks that would keep them informed of training opportunities. If they do learn of such training, barriers may prevent them from participating, especially if they are low-income providers. Barriers include the cost of the training, training schedules that conflict with providers' hours of operation, training tailored to center care rather than family child care, or language differences. As a result, while training, like regulation, is seen by experts as a critical element in improving the quality of child care, it can be difficult for family child care providers to obtain.

---

[6] B. Willer, S. Hofferth, E. Kisker, and others, The Demand and Supply of Child Care in 1990: Joint Findings from the National Child Care Survey 1990 and a Profile of Child Care Settings, National Association for the Education of Young Children, U.S. Department of Education, U.S. Department of Health and Human Services (Washington, D.C.: National Association for the Education of Young Children, 1991), p. 60.

A Variety of Organizations Work to Improve the Quality of Family Child Care

Many organizations sponsor initiatives to improve the quality of family child care. While their goals, purposes, and approaches to working with providers may differ, an overarching goal of all these efforts is to support providers by developing their professionalism and enhancing the quality of care they provide. Organizations involved with this work include resource and referral agencies,[7] community-based nonprofit organizations, cooperative extension agencies,[8] and public agencies, to name a few. Some focus on one or two activities, such as training, connecting providers to information and resources about health issues, or helping providers get licensed. Others weave together many activities into a more comprehensive network of support. As discussed later in this report, the organizations put together funding from different sources, both private and public, to support their activities.

SCOPE AND METHODOLOGY

Since we could not identify a single database that provided a comprehensive listing of initiatives targeted at improving the quality of family child care, we developed one through discussions with experts, literature review, and an information request on Internet. Our database, which consists of 195 family child care quality initiatives, was built primarily on the work conducted by the National Center for Children in Poverty, the Families and Work Institute, the National Council of Jewish Women, and MACRO International. By putting together these different information sources and adding information on other initiatives we found, we believe that we have constructed the largest single database of family child care quality improvement initiatives. However, we could not determine the extent to which our database represents the universe of initiatives nationwide. While the database contains information on a number of the initiatives' characteristics, we used it primarily to determine the funding sources for each initiative. However, while all the initiatives identified their sources of funding, very few provided the amount of funding from each source.

---

[7] Resource and referral agencies match parents looking for child care with providers. Typically, the agencies are funded by state or local child care agencies, private employers, or both. In addition to helping parents find care, resource and referral agencies provide services such as training or provider orientation classes.

[8] Cooperative extension agencies are entities found in every land grant university in the United States and conduct community outreach and education efforts. They are funded by USDA's Cooperative Extension Service.

We conducted site visits at 11 initiatives in three states: Georgia, Oregon, and California. The sites, which were highlighted in the literature we reviewed or in our discussions with experts, were judgmentally selected. We also visited family child care programs for three branches of the military--the Army, Navy, and Air Force--at installations in Maryland and Washington, D.C.

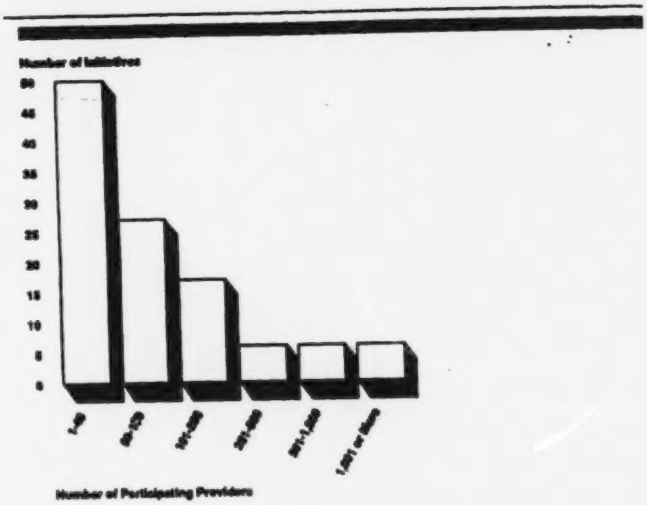
In addition, we (1) interviewed experts and officials from the Administration for Children and Families, the Head Start Bureau, and the Maternal and Child Health Bureau at HHS; the Department of Defense (DOD); and the Food and Nutrition Service at USDA; (2) reviewed the literature about issues in family child care; and (3) analyzed funding data gathered for our database.

We performed our work between April and October 1994 in accordance with generally accepted government auditing standards.

DIFFERENT APPROACHES USED TO IMPROVE QUALITY OF FAMILY CHILD CARE

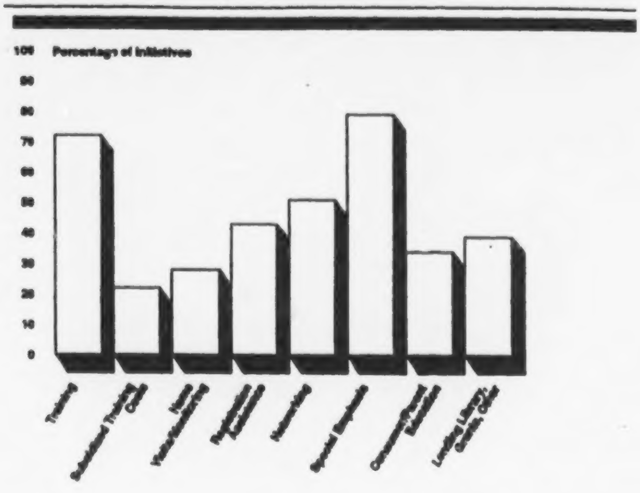
Our analysis of the 11 initiatives we visited showed three approaches used to foster quality care: (1) support networks; (2) training, recruitment, and consumer education initiatives; and (3) health initiatives. Regarding the last two categories, the initiatives described here employed more than one activity in working with providers; however, we designated them according to their key or primary activities. Appendix I describes each of the 11 initiatives we visited in detail. Characteristics and activities of the 195 initiatives in our database are shown in figures 1 and 2 (the number of providers participating in the initiatives and the services provided by the initiatives, respectively), and table 1 (the initiatives' funding sources).

Figure 1: Number of Providers Participating in Family Child Care Initiatives



Note: Of the 195 initiatives in our databases, information on the number of participating family child care providers was available for 112.

Figure 2: Services Provided by Family Child Care Initiatives



Note: "Special emphasis" means that the initiative focused on a particular population such as working with low-income providers or serving children with special needs.

Because initiatives provide multiple services, the percentages add to more than 100 percent.

BEST COPY AVAILABLE

Table 1: Funding Sources Used by Family Child Care Quality Initiatives

Total initiatives: 195

Source	Initiatives that received funds	Percentage of total initiatives
Federal		
Child Care and Development Block Grant	80	41
Child and Adult Care Food Program	58	30
Other	43	22
State	38	19
Local	38	19
Private	107	55
Private only	43	22

Note: Because initiatives had more than one funding source, column totals will exceed 195 initiatives and 100 percent.

Support Networks

Five initiatives we visited seek to create a support network for providers.[7] Typically support networks are part of an organization that, through a coordinator and staff, provides resources, support, and ongoing training to a group of family child care providers. For example, the Foundation Center for Phenomenological Research in California enrolls all of its family child care providers in the Montessori Teacher Education program. This program leads to the completion of requirements for the American Montessori Society diploma. Similarly, DOD's family child care system has an extensive entry-level and ongoing training system.

---

[7] These initiatives were the Neighborhood Child Care Network; Foundation Center for Phenomenological Research; Oakland Head Start Family Child Care Demonstration Project; Head Start of Lane County; and DOD's child care system. (See app. I for descriptions of these programs.)

Support network staff usually make regular visits to provide technical assistance, bring supplies and toys, or conduct training. The network also assists providers in becoming registered or licensed. In addition, all five initiatives link their providers to USDA's food program, which provides federal subsidies for nutritious meals and snacks served in child care facilities, including family child care homes, as long as the providers are state registered or licensed. The food program also provides regular training and monitoring visits. The five network initiatives also help or encourage providers to become members of local family child care associations or informal support groups. Given the large number of family child care providers, the development of associations--seen by experts as an important way to reach, support, and help train providers--is a key strategy in many initiatives focused on family child care.

Research on child care quality shows that the types of activities support networks conduct contribute to enhancing the level of professionalism of the provider and, thus, improve the quality of child care.

The funding for these initiatives comes from a full range of sources: private, state, and federal. Two of the initiatives we visited were solely federally funded: the Oakland Head Start Family Child Care Demonstration Project and DOD's child care system.

Training, Recruitment, and Consumer Education Initiatives

Three of the initiatives we visited--the Family-to-Family project, the California Child Care Initiative Project, and the Oregon Child Development Fund--focus on a combination of training and recruitment activities or training and consumer education. Additionally, the California and Oregon projects contain explicit and well-developed components for fundraising and disbursing money to various family child care projects across their states. (See app. I.)

The Family-to-Family project focused on improving the quality of care in family child care settings in 40 communities nationwide (see app. I). The initiative was sponsored by the Dayton Hudson Foundation, the philanthropic arm of the Dayton Hudson corporation, which fully funded--typically through 2- and 3-year grants--all 40 sites and committed over $10 million to the effort.

The initiative was built on a model that incorporated the following strategies: offering training to providers that was specifically tailored for family child care, promoting and supporting provider accreditation and professional associations, and contributing to local consumer education about selecting child care. The initiative identified an organization in each community that would be responsible for implementing and institutionalizing the strategies in the community during the life of the grant. It also launched a nationwide consumer education campaign to help parents recognize quality child care. In doing this, the initiative wanted to create a demand for quality care, thereby prompting the child care market to supply it.

We visited one of the initiative's first sites, located in Salem, Oregon. Staff involved with the project told us that before the Family-to-Family initiative, little work had been done with family child care in the state. For example, Oregon had only a voluntary registration system for family care providers, and provider associations were not very strong or active. According to the staff, the initiative acted as a catalyst in building supports for family child care as evidenced by the birth of the Oregon Child Development Fund, development of a statewide resource and referral system, and state enactment of minimum requirements for family child care settings.

The California initiative and the Oregon fund also focus on training and recruitment and, as mentioned earlier, have successful fundraising components. These initiatives use a five-part model that consists of assessing community child care needs, recruiting providers to meet those needs, offering technical assistance so providers can become licensed, providing ongoing training to providers, and giving them ongoing support. These components are implemented by a statewide resource and referral system. However, it became apparent early in the initiatives' development that more funding was essential to carry out the model, particularly to support the recruitment, training, and networking activities of the various family child care projects. By continually developing funding partnerships with local and nationwide businesses, foundations, and governments, the California initiative has raised $6.8 million in the last 9 years to fund its family child care projects. The Oregon Child Development Fund, which is a replica of the California initiative, was first funded in 1990. Currently, it has raised $500,000, which it leveraged into an additional $1 million for family child care projects in the state.

Health Initiatives

Three of the initiatives we visited were health initiatives that focus on family child care.[10] While their purposes encompass a number of specific goals and objectives, in the broadest sense, all aim at increasing the health and safety practices in family child care homes. Two of the three also have increasing the immunization rates of children in family child care as one of their objectives.

All three initiatives plan to use an education strategy to inform providers of health and safety practices and to help link them to other resources. For example, an initiative we visited in Hood River, Oregon, uses two county health departments and the local child care resource and referral agency to provide consultations on health, nutrition, and other related issues to family child care providers in those counties. The health departments provide a public health nurse who makes home visits to providers, answers questions over the telephone, and conducts training sessions on health and nutrition issues.

Two of the health initiatives are funded with federal grants from the Maternal and Child Health Services Block Grant. The block grant is administered by the Maternal and Child Health Bureau in HHS. The third initiative receives CCDBG money to fund most of the project; it also uses some immunization planning funds that states receive from the Centers for Disease Control and Prevention, which is part of HHS.

FAMILY CHILD CARE QUALITY INITIATIVES ARE FINANCED WITH PUBLIC AND PRIVATE FUNDS

Federal Child Care Funds Are Primarily for Subsidies

The federal government's role in child care has been primarily one of helping parents pay for child care. Of the seven major sources of federal support for child care, six have the primary purpose of subsidizing the cost of care for parents. These programs are the (1) Dependent

---

[10] The three health initiatives were the Atlanta Family Child Care Health and Safety Project, the Oregon APHA Project (APHA stands for the American Public Health Association), and the Family Day Care Immunization Project. (See app. I for details about the initiatives.)

Care Tax Credit, (2) Social Services Block Grant, (3) Child and Adult Care Food Program, (4) Child Care for AFDC, (5) Transitional Child Care, (6) At-Risk Child Care, and (7) CCDBG. Total federal support for these programs amounted to approximately $8 billion in fiscal year 1993. Of the $8 billion, approximately $156 million was for quality support activities, such as training and monitoring, in all types of child care settings.[11] (How much of this amount goes exclusively to quality initiatives for family child care could not be determined.) The largest amount of indirect federal support for child care is provided through the Dependent Care Tax Credit--$2.4 billion in fiscal year 1993--and is provided through the tax code to working individuals. The remaining programs provide direct federal funding to states for child care to be used for the allowable activities established by each funding stream. Table 2 provides more information about these programs.

---

[11] We derived this estimate by calculating 5 percent of the total CCDBG fiscal year 1993 obligation figure and adding $113 million for administrative costs for USDA's food program in 1993. (See table 2.) However, this figure may be underestimated for two reasons. First, while CCDBG requires that 5 percent of total funds be used for quality improvement activities as defined by statute, states may spend an additional 12.5 percent of total funds for administrative costs, availability of services (increasing the supply of child care), or quality activities upon petitioning HHS to do so. If all states spent the additional 12.5 percent on activities to improve quality, it would raise our total estimate to approximately $264 million. Second, we found a few initiatives that received money from the Child Care for AFDC program. The money they received was mostly used to pay for care of children of AFDC recipients or those in the Job Opportunities and Basic Skills program. But they also used a small percentage of the money for administrative costs, some of which included quality activities to support their providers. However, we could not calculate the amount of money they used for quality activities.

Table 2: Major Federal Funding Sources for All Child Care Settings for Fiscal Year 1993

Funding source	Amount (millions)	Purpose	Agency
Dependent Care Tax Credit	$2,450[a]	To provide child care subsidies in the form of a limited tax credit[b]	Treasury
Social Services Block Grant	2,800[c]	To provide funding for state social service activities, including child care subsidies[d]	HHS
Child and Adult Care Food Program	1,226[e]	To provide federal subsidies for meals served in care facilities[f]	USDA
Child Care and Development Block Grant	863[c]	To provide child care subsidies for low-income families and to improve the overall quality of child care for families in general	HHS
Child Care for AFDC	470[g]	To provide child care subsidies to AFDC recipients who are in training or working	HHS
At-Risk Child Care	270[g]	To provide child care subsidies to families at risk of going on welfare	HHS
Transitional Child Care	113[c]	To provide child care subsidies for up to a year to families who have left AFDC	HHS

[a] Projected amount of credit claimed for fiscal year 1993.

[b] The Dependent Care Tax Credit is also allowed for other dependents such as an incapacitated spouse. The Internal Revenue Service estimates that for 1992 tax returns, approximately 98 percent of the returns claiming this credit had child dependents. However, the extent to which the credit is used to offset child care costs as opposed to costs for care of other dependents is unknown.

[c] Appropriated amount for fiscal year 1993. Expenditure data are not available.

[d] An HHS official stated that prior to the program becoming a block grant, the percentage of the funds used for child care had been approximately 20 percent. Since that time, the actual percentage is unknown. However, block grant funds spent for child care are used to subsidize the cost of care for eligible families.

[e] Expenditures for fiscal year 1993.

[f] According to an official of the Food and Nutrition Service, approximately $1.1 billion of the $1.2 billion expended in 1993 went to child care facilities (centers and homes) as opposed to adult care facilities. The amount of money going to family child care homes for meal subsidies was approximately $610 million for 1993, while the amount going for administrative costs (which support training and monitoring activities) was approximately $113 million. However, the administrative costs figure includes expenditures for both centers and family care homes.

[g] Obligations for fiscal year 1993. Complete expenditure data are not available.

While the tax credit is primarily used by families earning above $20,000 a year, four of the recent federal programs are aimed at poor families: Child Care for AFDC, Transitional Child Care, At-Risk Child Care, and CCDBG. These programs are designed to help welfare recipients and working poor families achieve economic self-sufficiency by giving them assistance with child care. Enacted through the 1988 Family Support Act and the 1990 Omnibus Budget Reconciliation Act, these programs made approximately $1.7 billion available to the states in fiscal year 1993. Again, the primary purpose of these programs is to subsidize the cost of child care.

BEST COPY AVAILABLE

The primary purpose of USDA's Child and Adult Care Food Program is to subsidize the cost of nutritious meals for children in various care settings. It also provides other support such as training and monitoring to providers who become licensed or registered. Unlike the other federal child care programs, USDA food program subsidies received by family child care providers are not exclusively for poor children.

CCDBG Is the Federal Funding Used Most

The most frequently used source of federal funds to support quality enhancement initiatives in family child care was CCDBG. Eighty of the 195 initiatives in our database, or 41 percent, received CCDBG funds. Unlike other federal child care funding, which only provides subsidies, CCDBG sets aside a small amount of money--5 percent of a state's total CCDBG grant--that the state is required to spend on quality improvement activities in all types of care settings. For 1993, this would have amounted to approximately $43 million.[11] The allowable activities include some of those provided by the initiatives we visited: training providers, supporting resource and referral agencies, improving licensing and monitoring activities, improving compensation for providers, and helping providers meet state and local child care regulations. While CCDBG quality improvement money must be used for these activities, it is money that is flexible (that is, it is not targeted for a certain population) and accessible to many organizations (that is, different types of groups can apply for it).

USDA's Food Program Is the Second Most Frequently Used Federal Funding Source

The other federal funding source most often used to support quality initiatives for family child care was USDA's Child and Adult Care Food Program. Fifty-eight of the 195 initiatives in our database, or about 30 percent, received food program money. In addition to providing subsidies to family child care providers for nutritious meals and snacks, the program also provides administrative money to the organization that sponsors the providers.[13] This money goes to supporting staff who train providers on the required nutritional guidelines children's meals must meet under the program, make periodic monitoring visits, and provide technical assistance to plan menus and fill out reimbursement paperwork. Providers must be state licensed or registered to participate. Because of its unique combination of resources, training, and oversight, experts believe the food program is one of the most effective vehicles for reaching family child care providers and enhancing the care they provide.[14]

---

[11] States are allowed to spend up to an additional 12.5 percent of their total block grant money on administrative costs, availability of services, or quality improvement activities.

Other Federal Funding Sources Exist, but Are Used Less Frequently

While federal sources other than CCDBG and USDA's food program were used by different initiatives for promoting quality in family child care, these sources were used less frequently. We found 43 out of 195 initiatives--22 percent--received funding from other federal sources. These funds were from at least five different programs: the Child Care for AFDC program money authorized under the Family Support Act and administered by HHS; the Community Development Block Grant and Public Housing Demonstration Grants administered by the Department of Housing and Urban Development; the Cooperative Extension Service,[15] a USDA program; and the Maternal and Child Health Block Grant administered by HHS. These funds tend to be more restricted than CCDBG and USDA food program funds. For example, we found a few initiatives using Child Care for AFDC program money to support their activities, but most of the money was used to subsidize the cost of child care and was only available to these particular initiatives because they served children of AFDC recipients. Similarly, the Community Development Block Grant money for family child care quality initiatives is only available in communities that receive funds from that block grant and then only if the communities have targeted family child care as a priority.

---

[13] A family child care provider must go through a food sponsor and cannot apply directly to the USDA program.

[14] The administration's welfare reform legislation, which was introduced in the last Congress, proposed changing USDA's food program to a means-tested program; this means meal subsidies to providers would be reduced if the children they served did not meet certain income eligibility requirements. Currently, the food program does not have income requirements for families of children served in family child care homes. If these changes are enacted by the 104th Congress, some experts and advocates are concerned they may cause providers to drop out of the program and undercut the program's current quality support activities for family child care providers.

[15] The Cooperative Extension Service is not a funding stream per se; organizations cannot apply for money to support their family child care initiatives. But the Service conducts outreach and education efforts in the communities it serves, including some that focus on work with family child care providers.

Private Funding Plays a Major Role in Supporting Initiatives

In addition to federal money, private dollars have played a major role in funding these initiatives. Private funding came from a variety of sources, including foundations, endowments, businesses, charities, fundraising, and user fees. Of the 195 initiatives in our database, 107, or almost 55 percent, received money from at least one private source; 43 initiatives, or approximately 22 percent, received money only from private sources. For example, two initiatives we visited--the Neighborhood Child Care Network and the Family-to-Family initiative--were originally funded by a large foundation and a private business, respectively. Two other initiatives mentioned earlier, the Oregon Child Development Fund and the California Child Care Initiative, built and manage a funding supply for family child care initiatives in these states. The Oregon fund is financed entirely with private dollars, and only 7 percent of the $6.8 million that the California initiative raised in the last 9 years was federal money.

IMPLICATIONS FOR WELFARE REFORM

There is growing evidence that the environment in which children grow plays a vital role in supporting or impeding their healthy development. Research shows that children learn from birth--long before they are actually in a classroom--and that their success or failure in that classroom can be, in part, tied to their early environment. Given that many children, especially very young children, are spending significant parts of their day in child care, communities, experts, and policymakers are asking questions about the quality of that care.

Experts have had long-standing concerns about the quality of child care in the United States for all types of settings. In light of these concerns, the initiatives we found were engaged in strategies and activities to improve the quality of family child care by providing networks of support and other resources. They gave family child care providers ongoing training, linked them to information and resources, helped them to become registered and to join the USDA food program, provided access to toy-lending libraries, and supported them with staff who made home visits to provide various types of help. Again, research tells us that such activities can significantly enhance the quality of care children receive.

Many welfare reform discussions outline plans to require more AFDC recipients to either work or be in education or training programs to help them acquire basic skills for supporting their families. As a result, the number of children needing child care--particularly very young children--is predicted to grow. Since family child care is the choice of a significant proportion of poor families with infants and toddlers, its use is also predicted to grow under various welfare reform scenarios. Given that research shows that quality child care settings particularly benefit poor children, the need for quality in this care will also grow.

- - - - -

At your request, we did not obtain written agency comments. However, we discussed our findings with agency officials who generally agreed with the information presented in this report.

We are sending copies of this report to the Secretary of Health and Human Services, the Secretary of Agriculture, and to other interested parties. We will make copies available to others on request.

Major contributors to this report are listed in appendix II. If you have any questions concerning this report or need additional information, please call me on (202) 512-7215.

Sincerely yours,

Leslie G. Aronovitz

Leslie G. Aronovitz
Associate Director
Income Security Issues

CONTENTS

LETTER 1

APPENDIXES

I EXAMPLES OF QUALITY INITIATIVES FOCUSED ON FAMILY CHILD CARE 22
II MAJOR CONTRIBUTORS TO THIS REPORT 31

TABLES

1 Funding Sources Used by Family Child Care Quality Initiatives 10
2 Major Federal Funding Sources for All Child Care Settings for Fiscal Year 1993 15

FIGURES

1 Number of Providers Participating in Family Child Care Initiatives 8
2 Services Provided by Family Child Care Initiatives 9

ABBREVIATIONS

AFDC	Aid to Families With Dependent Children
APHA	American Public Health Association
CCDBG	Child Care and Development Block Grant
DOD	Department of Defense
HHS	Department of Health and Human Services
USDA	U.S. Department of Agriculture

EXAMPLES OF QUALITY INITIATIVES FOCUSED ON FAMILY CHILD CARE

This appendix contains brief descriptions of the 11 initiatives we visited, including information on the strategies used, the sponsoring organization, the amount of funding received, and the number of providers served by the initiative. The 11 descriptions are categorized as support networks; health initiatives; and training, recruitment, and consumer education initiatives.

SUPPORT NETWORKS

Neighborhood Child Care Network

The Neighborhood Child Care Network, an initiative sponsored by Save the Children in Atlanta, started as a national demonstration project funded by the Ford Foundation. The Network's goal is to improve the quality and availability of family child care for low-income parents. It has set out to demonstrate what urban communities can do to address child care issues through community organizing and formal and informal training of providers.

The Network supports 60 family child care providers in the communities it serves. The Network's support includes lending libraries from which their providers can borrow books, equipment, and toys; regular home visits from child care specialists who conduct one-on-one training with providers, discuss relevant child care topics such as child development and safety and health issues; assistance with joining the USDA food program, record keeping and other business aspects; monthly training workshops and newsletters that list other training opportunities; scholarships to attend training conferences; and assistance in forming family day care provider associations and obtaining national accreditation.

In 1992, the Network expanded its activities to include services for the parents in its family child care network. Through a grant from A.L. Mailman Family Foundation and Primerica, its Parents Service Project uses family child care homes as the parents' point of entry for delivery of various social services.

The Network was funded from 1987 through 1990 with grants from the Ford Foundation that totaled approximately $300,000. Since then, it has received a total of approximately $120,000 in CCDBG money, which has required the Network to curtail some services.

Save the Children is an international nonprofit organization whose mission is to improve the lives of poor children and their families. It was founded in 1932 and works in Appalachia, in several southern states, and selected inner-city areas as well as in 43 other countries.

Foundation Center for Phenomenological Research

The Foundation Center for Phenomenological Research is a nonprofit organization formed in 1974 to help small community organizations strengthen their operations. In 1980, it won its first contract to run a state-funded child care program; currently it runs child care programs in approximately two dozen locations, primarily in California. The site we visited was its Sacramento Delta and Ilocer Migrant and Seasonal Farmworker Family Child Care Project, which supports 20 providers serving approximately 160 children from migrant agricultural workers' families.

The goal of the Foundation Center is to provide quality child care to infants, toddlers, and preschoolers and their families and to improve the children's school readiness and long-term academic achievement. The Foundation Center provides health services to the children and their families and a full-day education program for the children, and also supports family child care providers. The Foundation Center gives providers employment benefits, including sick and vacation leave, and health insurance; recruits and places eligible children in providers' homes, helping to complete paperwork requirements for child care funding and USDA's food program; provides training in the providers' native languages using the Montessori curriculum so that providers can earn the American Montessori Society teaching credential; and equips each provider's home with culturally and developmentally appropriate furniture, materials, and toys. Additionally, all children and their families receive free yearly health exams, immunizations, medications, referrals, and follow-up, and are linked to other social services they may need.

The Foundation Center's family child care projects are funded with state dollars through California's General Child Care funds. The only federal assistance the Foundation Center receives is as a food sponsor through USDA's food program. It receives a total of approximately $9 million a year from these sources to serve 2,300 children at 20 sites, including family child care projects, in 9 California counties.

Oakland Head Start Family Child Care Demonstration Project

In 1992, HHS began a demonstration project to determine if family child care could be a viable way to deliver the comprehensive services that are required of Head Start programs. Currently, HHS has funded, for 3 years, 17 Head Start Family Child Care Demonstration Project sites across the country. The demonstration, which includes only 4-year-olds, requires family child care providers to meet the Head Start Performance Standards.

At the project site in Oakland, California, the low-income families who participate must be working or in an education or training program, thus requiring more than the half-day services traditionally provided by Head Start centers. All providers in the family day care project offer full-day and year-round care, a primary reason that Oakland applied for the demonstration project. City officials were finding that more and more of the child care needs of their low-income families could not be met with centers that operated only half the day. The 7 providers participating in the Oakland project care for approximately 40 children.

Head Start family child care providers participating in the Oakland demonstration received 40 hours of preservice training in 1993 and 80 hours in 1994. After the preservice training, they attend training once a month. In addition, providers receive weekly visits from a child care specialist. These visits, which last from 20 minutes to a few hours, allow the specialist to observe the provider and children, deliver supplies and materials, link the provider with the other Head Start coordinators, and support the provider in other ways.

Head Start is a fully federally funded program administered by the Head Start Bureau at HHS.

Head Start of Lane County

While Head Start of Lane County is a federal Head Start grantee, its family child care model--which uses family child care providers to serve Head Start-eligible children--is funded by the Oregon Pre-Kindergarten Program. The state program, which is a replica of the federal Head Start program, was begun in 1990 as a way to serve more low-income children in a Head Start model. Lane County Head Start officials decided to use family child care providers when they identified a need to provide Head Start services in two rural areas of their county where no Head Start centers were located. At the time of our visit, the program had 20 providers serving 80 children between the ages of 3 and 5. For 1993-94, Lane County Head Start received a state grant of approximately $292,000 to administer the program.

While this model is funded with state dollars, the family child care providers are treated as Head Start teachers and, as in the Oakland Head Start Demonstration Project, the care they provide must meet Head Start standards. During 1993-94, each family child care provider received approximately 75 hours of training. Providers also receive visits at least once a week from their Head Start trainer who works with the providers and the children in the providers' homes. And, because they are part of the Head Start program, the providers are linked with all the Head Start specialists who work with the children and parents enrolled in the center program.

The family child care model will not be continued in 1994-95, however. This is due to a reorganization by the grantee, which needs time to focus on its center-based program. However, Lane County Head Start officials told us that they hope to resume the program in the future.

DOD's Family Child Care System

As the largest employer in the United States, the military has experienced the same demographic trends in its workforce as other employers: increases in both the number of married personnel with spouses in the workforce and the number of single parents. Because of its flexibility to support the varying work hours of service personnel and to accommodate parental deployment with long-term care, family child care was seen as a viable way to meet the needs of military families. As a result, the four service branches have developed a comprehensive family child care system.

DOD's family child care model contains the same elements other support network initiatives do--ongoing training for providers; visits by home monitors; placement of children; and access to equipment, supplies, and other resources. However, DOD's system has notable differences, too: the huge organization that sponsors it; the large number of providers it supports (over 12,000 worldwide); the amount of authority it has to screen and monitor providers because they reside in military housing; and the full federal funding it receives.

Intensive screening of potential providers and extensive ongoing training for those accepted into DOD's network are two components of its model that stand out. Orientation sessions are held for prospective providers to familiarize them with the requirements for providing family child care on a base or installation. After the orientation session, the military begins its process of certifying both the provider and the provider's home. This involves yearly background checks on the provider and members of the household over the age of 12; in-home interviews with the provider and family members; a health, fire, and safety inspection of the home; and quarterly home monitoring visits.

Training for providers includes orientation, initial, and annual training requirements. Orientation training must be completed by providers before working with children and covers topics such as child health and safety, age-appropriate discipline, and applicable child care regulations. Once hired as a family child care provider, an individual must complete a minimum of 36 hours of initial training within 6 months of being hired. This training provides more in-depth coverage of topics such as nutrition, cardiopulmonary resuscitation, and child development. After this, providers must complete a minimum number of hours of ongoing training each year; the requirements differ for each service branch.

HEALTH INITIATIVES

Atlanta Family Child Care Health and Safety Project

The Atlanta Family Child Care Health and Safety Project, conducted by Save the Children's Child Care Support Center, is a 3-year project running from October 1993 through September 1996 that is designed to address the increased health and safety risks faced by children in family child care. HHS is providing $300,000 for the project through the Maternal and Child Health Block Grant administered by the Maternal and Child Health Bureau.

The project's first goal is to improve the existing system of training and support for child care providers. To accomplish this, project staff will refine an existing health and safety checklist for child care providers and develop educational materials for parents and child care providers that discuss, among other things, safety and health issues in a family child care setting. In addition, project staff will conduct a study of a group of family child care providers to identify barriers they face in meeting health and safety standards as well as identifying barriers to training and other support. Staff will also explore methodologies for collecting information on injury and illnesses occurring in family child care settings. (Currently injury and illness data in child care settings are gathered only for center care.) This research will provide useful information for designing training programs and educational materials on health and safety issues specifically tailored for family child care.

The second goal, which is not exclusively focused on safety and health issues, is to bring unregistered family child care providers into the system of registration, training, and support. Project activities related to this goal include increasing provider registration, particularly through registering providers who take care of subsidized children; enrolling providers in USDA's food program; listing providers with child care resource and referral services; assisting providers in meeting health, safety, and training requirements; and encouraging participation in professional provider associations.

Oregon APHA Project

Oregon is one of the four states selected to pilot the implementation of guidelines developed by the American Public Health Association (APHA) in conjunction with the American Academy of Pediatrics.[16] A 1-year demonstration project, the Oregon APHA Project, is funded with $20,000 in CCDBG money provided by the state Child Care Division and $10,000 in Immunization Grant money provided by the state Department of Human Services, Health Division. The Immunization Grant is provided to states by HHS's Centers for Disease Control and Prevention to help states plan and execute community immunization plans.

The dual objectives for the demonstration project are to (1) form strong links with public health and other community organizations to establish a planned public health strategy to improve the overall health of children in child care settings and (2) increase the immunization rates of children in such settings.

Three Oregon counties, Hood River, Sherman, and Wasco, are involved in the pilot. While the initiative has a number of objectives, those related to family child care include facilitating provider access to ongoing health promotion, protection, and education and giving child care providers home safety assessment tools and necessary child safety items such as safety latches, smoke alarms, and socket plugs.

The project is using two county health departments and the local resource and referral agency to carry out the initiative. Through connections made by the resource and referral agency, a part-time public health nurse from the health departments consult with family child care providers on health and safety topics through home visits, phone calls, and training sessions organized by the resource and referral agency.

---

[16] See Caring for our Children: National Health and Safety Performance Guidelines for Out-of-Home Child Care Programs (Arlington, Va.: National Center for Education in Maternal and Child Health, 1992).

Family Day Care Immunization Project

The Family Day Care Immunization Project, sponsored by the Center for Health Training in San Francisco, is a 3-year demonstration project running from October 1993 through September 1996 funded by the Maternal and Child Health Bureau. Annual project funding is $100,000.

The specific project goal is to improve immunization rates of children, especially low-income and ethnic minorities, from a sample of family day care homes. Objectives include (1) increasing the knowledge and practice regarding immunization screening for at least 24 health care consultants by September 30, 1994, and (2) developing and testing at least three distinct educational interventions with up to 120 providers to determine their effectiveness in increasing immunization rates and their comparative costs by September 30, 1996.

Regarding the first objective, the Center plans to "train the trainers" to conduct training and site visits. Trainers are being recruited from agencies such as the Red Cross and California's Department of Social Services. The interventions proposed for the second objective will use three control groups: (1) one that will receive only notification letters of state immunization requirements, (2) one that will participate in a 3-hour training session, and (3) one that will receive a 1- to 2-hour site visit to provide information about immunizations. The project will determine which method is the most cost-effective for implementing California's new law requiring immunizations in family day care settings.

The Center is a private, nonprofit company that does health research and training, and provides consultant services about health activities.

TRAINING, RECRUITMENT, AND CONSUMER EDUCATION INITIATIVES

California Child Care Initiative Project

The California Child Care Initiative Project was begun in 1985 to increase the supply of quality family child care statewide. Originally designed and initiated by the BankAmerica Foundation, the project is a public-private partnership that includes over 473 foundations, corporations, local businesses, and public sector funders. It has raised over $6 million for its mission.

The project's purpose is to fund community-based child care resource and referral agencies to (1) recruit and train new family day care providers and (2) provide start-up and ongoing assistance to help them stay in business. The California Child Care Resource and Referral Network oversees the project's daily operations and manages its publicity and fundraising activities. The project's successful and effective fundraising component makes it unique among the initiatives we visited. The Network continually raises funds in the private and public sectors and also coordinates the state of California's contribution of up to $250,000 per year, matching $1 for every $2 raised from private businesses and federal and local governments.

Overall, the project has recruited 3,887 new, licensed family child care homes, making 15,303 new child care spaces available for children of all ages. Since the initiative began, over 25,891 family child care providers have received basic and advanced training in providing quality child care. Because of its success, the project is being replicated in Oregon (see the next section), Illinois, and Michigan.

Oregon Child Care Initiative and Oregon Child Development Fund

The Portland-based Oregon Child Care Initiative, which is a replica of the California Child Care Initiative, was incorporated to solicit funds from corporate, foundation, and private sources to encourage solutions to family child care issues in Oregon. The primary mission at its inception was to increase access to stable and quality family child care. Efforts to accomplish this broad goal included using proven provider recruitment, training, and retention programs first developed under the California model. In 1992, the initiative evolved into the Oregon Child Development Fund with a broader mission of increasing access to stable, high-quality child education and child care services by concentrating fund raising and distribution in four areas: training and recruitment, consumer education, capital expansion, and accreditation scholarships.

As with the California initiative, the Oregon project's funding mechanism is one of its distinctive components. The Oregon project was originally funded by the Ford Foundation in 1990 with actual start-up in 1991. Currently, it has raised $500,000 in grant funding, which it has leveraged into an additional $1 million in local and state support. According to a representative of the fund, the project is entirely supported by private or business donations.

Between 1990 and 1993, the initiative recruited 3,000 family child care providers, trained 3,400 family child care providers, created 18,000 child care slots, and awarded 21 scholarships to providers seeking National Association of Family Child Care accreditation or Child Development Associate credentialing.

Family-to-Family Initiative

The Family-to-Family initiative was funded by the Dayton Hudson Foundation, the philanthropic arm of the corporation that owns Mervyn's and Target department stores throughout the midwest, northwest, and California. In 1988, the corporation executives became concerned about the difficulty employees were having in finding quality family child care and the limited information parents had to identify quality child care. Through its corporate foundation, Dayton Hudson initiated a nationwide campaign to address these issues. The strategy was to promote training, accreditation, and consumer education at selected sites through a collaborative effort with community-based organizations so that these efforts would continue after the initiative ended.

The first four sites funded by the initiative were in Oregon; we visited the Salem site. With a $250,000, 2-year grant from Dayton Hudson and through two partners in the community--a community college and the local resource and referral agency--the initiative established a structured training program for family child care providers, promoted and assisted with accreditation, and began a statewide consumer education campaign. In addition, the initiative established a provider council and toy- and equipment-lending libraries for providers. The council was important to help develop provider leadership in the community and to create a forum at which family child care issues could be discussed and strategies could be developed to address them. Toy- and equipment-lending libraries helped subsidize the cost of operation for providers, especially for those caring for infants who needed cribs and other more expensive equipment.

One of the most critical and lasting effects of the Family-to-Family initiatives was to establish a structured provider training program at community colleges, resource and referral agencies, USDA community colleges, and other organizations throughout Oregon to make it accessible and transferrable no matter where providers took courses. The courses were designed to satisfy requirements leading to a child development associate's degree.

MAJOR CONTRIBUTORS TO THIS REPORT

Lynne Fender, Assistant Director, (202) 512-7229
Janet L. Mascia
Alexandra Martin-Arseneau
Diana Pietrowiak

STATEMENT BY

MARY JO BANE

ASSISTANT SECRETARY

ADMINISTRATION FOR CHILDREN AND FAMILIES

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE

HOUSE COMMITTEE ON SMALL BUSINESS
SUBCOMMITTEE ON REGULATION, BUSINESS OPPORTUNITIES,
AND TECHNOLOGY

DECEMBER 9, 1994
PORTLAND, OREGON

Chairman Wyden, and members of the Committee, thank you for giving me the opportunity to come before you today to speak about the issue of child care -- an issue of critical importance to our nation's children and families.

This morning, all across the nation, millions of young children are participating in some form of child care while their parents are working or receiving training and education. The dramatic increase in labor force participation of mothers has heightened attention to child care in recent years. By 1993, three-quarters of all mothers with children aged 6-17, and sixty percent of mothers with children under age six, were in the labor force. Today, over half of all mothers whose youngest child is under age two are in the labor market. This high usage of child care increases our national stake in the quality of this important service. We must renew our efforts to ensure that through our federal child care programs we are promoting safe and healthy environments that foster the development and overall well-being of children.

Children are being cared for in a wide range of settings. Some are in their own homes; others are in family day care homes, where a single provider cares for a small number of children in a residential setting; others are in larger, more formal child care centers, which are staffed by a number of providers.

Because of the variety in the existing system, different approaches for ensuring quality are appropriate. However, all children should enjoy basic health and safety protections and be in environments that enhance their growth and development. Today, many children are in healthy, safe, and secure environments, but others are not so fortunate. It is critical for the Federal government, in partnership with States, communities, providers, and parents, to work towards ensuring that all child care is provided in safe, healthy, and nurturing settings.

As Assistant Secretary of the Administration for Children and Families (ACF), I am responsible for the administration of ACF's child care programs. I will focus my remarks on an overview of these ACF programs, initiatives we have underway to provide consistency and coordination across programs, and activities to improve quality.

ACF Child Care Programs

The ACF administers a variety of programs to help low-income families obtain child care services. ACF child care services focus on assisting individuals in low-income families who are employed, or in education and training for employment, and who need child care to achieve self-sufficiency. ACF programs also serve families with children that need protective services. The

Child Care and Development Block Grant (CCDBG) provides Federal funds to the States, Territories, and Tribes for child care assistance. Title IV-A of the Social Security Act provides Federal funds to States for child care for AFDC recipients, Transitional Child Care, and At-Risk Child Care. This care is subject to applicable standards of State and local law. All providers receiving funds under the CCDBG program must meet health and safety requirements set by the States in certain areas, including the prevention and control of infectious diseases, building and premises safety, and provider training. We know that over half the States have elected the option to expand these CCDBG requirements to title IV-A child care.

The Child Care and Development Block Grant. CCDBG provides low-income families with the financial resources to access child care. In addition, CCDBG increases the availability of early childhood development and before- and after-school child care services and provides funds to improve child care quality and supply. Funds are available to States, Indian Tribes, and Territories to provide grants, contracts, and certificates for child care services for low-income families. To be eligible, a family must need child care because a parent is working or attending a training or educational program or because the family receives or needs to receive protective services.

Funding for CCDBG became available in September 1991 and has grown from $732 million in the first year to $893 million in FY 1994.

In FY 1994, CCDBG funds were distributed to all fifty States, Puerto Rico, the District of Columbia, four Territories, and 221 Indian Tribes. Preliminary data indicate that in FY 1993 over 750,000 children received child care services paid for in whole or part with CCDBG funds.

AFDC Child Care. Title IV-A of the Social Security Act provides child care entitlement funds for individuals receiving benefits through the Aid to Families with Dependent Children (AFDC) program. This child care allows them to pursue employment or approved education or training which will help them to become economically self-sufficient.

In FY 1993, approximately 340,000 children received services in an average month. Of the families served, approximately 70 percent are participants in the JOBS program. (Under the Family Support Act, child care is guaranteed for working recipients, as well as JOBS participants and those in other approved education and training activities. Working AFDC recipients may receive child care benefits directly through this program or through the AFDC dependent care disregard to their earned income.)

Transitional Child Care (TCC). TCC is another child care entitlement under title IV-A. Under TCC, child care assistance is continued for up to 12 months beginning with the month the family becomes ineligible for AFDC as a result of increased work hours, higher earnings, or the loss of the time-limited earned income disregards.

Receipt of transitional child care has continued to grow since it was first made available in April 1990. Data for FY 1993 indicate that nearly 85,000 children were served in an average month.

At-Risk Child Care Program (ARCC). ARCC provides States the option, under title IV-A, of providing child care to low-income working families who are not receiving AFDC, who need child care in order to work, and who are otherwise at risk of becoming dependent on AFDC. ARCC is funded as a capped entitlement. For FY 1993, 47 States and the District of Columbia voluntarily reported serving an average of about 219,000 children per month. All 50 States and the District of Columbia now have approved At-Risk Child Care Programs.

Consistency and Coordination

ACF has taken important steps over the past year to ensure better consistency and coordination among its child care programs. First, last spring, ACF developed and published a Notice of Proposed Rule Making designed to remove barriers to coordination of child care services and to support States, Territories, and Tribes in improving the quality of care. The changes it proposed cover all four ACF child care programs and reflect input gathered from monitoring reviews and consultations with a wide variety of individuals and organizations across the country. We received over 250 comments on the proposed rule, which we are now analyzing. We hope to publish final regulations this winter.

Second, the Administration's welfare reform proposal, the Work and Responsibility Act of 1994, included several provisions to make the IV-A child care programs consistent with the Child Care and Development Block Grant, creating a more seamless child care system. The proposal simplifies administration of the child care programs, in part by further standardizing their requirements for provider standards, health and safety, parental access, consumer education, parental choice, and parental complaint management. It also proposed uniform reporting and planning in an effort to relieve States of the burden of completing multiple forms and procedures.

Third, we are finalizing plans to consolidate the Federal administration of the four main child care programs administered by ACF into a Child Care Bureau. The Child Care Bureau will be housed in the Administration on Children, Youth, and Families.

The Child Care Bureau will provide national leadership and direction to improve the quality, supply, and affordability of child care for children and families across the United States, the Territories, and the Tribes. The Child Care Bureau will serve as a focal point for child care policy within the Federal government. It will plan, manage, and coordinate child care assistance for low-income children and families and provide information, training, and technical assistance to promote a wide range of quality child care options and effective linkages with other child, family, and health services. The Child Care Bureau has four goals:

- Improving services to families through modernization, efficiency, and improved coordination across child care funding streams.
- Providing comprehensive and high quality child care services to low-income families.
- Increasing the percentage of low-income families that receive child care assistance and support.

- Raising public awareness of our programs and of the importance of child care assistance to low-income families.

Since many other parts of the Department, as well as other agencies across the Federal government, are involved in child care, we have also convened a Federal Child Care Partners Group to help track, monitor, and expand Federal efforts in this area and to coordinate services better. We are very pleased that we have already enlisted the active participation from such agencies as the Public Health Service (including the Maternal and Child Health Bureau and the Centers for Disease Control and Prevention); the General Services Administration; the Corporation for National and Community Service; and the Departments of Education, Agriculture, and Labor, among others.

Supporting Quality Child Care

The Administration is strongly committed to improving the quality and supply of child care for children and families across the country through partnerships with grantees, communities, providers and the private sector. We know that among other things, quality care depends upon adequate health and safety standards, proper monitoring and enforcement, and a sufficient number of well-trained and supported staff. We also know that access to quality child care is critical to ensuring the health and safety of children, promoting healthy child development, ensuring that all children are ready for school, guaranteeing parental choice of care, and providing parents the peace of mind and the continuity and stability of care needed for them to succeed at work and maintain their economic independence.

The Child Care and Development Block Grant is the principal source of Federal support to strengthen the quality and enhance the supply of child care. Under the CCDBG program, 25 percent of the funds must be set aside for activities to improve the quality of child care and to increase the availability of early childhood development programs and before- and after-school care. Activities to support quality include: resource and referral assistance, grants or loans to assist providers in meeting State or local regulatory requirements, monitoring of compliance with State and local licensing and regulatory requirements, caregiver training, and improved salaries for child care staff.

Preliminary data indicate that about nine percent of the total CCDBG funds are spent on quality activities. States, Territories, and Tribes have initiated an array of projects with these funds to improve child care services. For example:

o Many States have launched efforts to improve their training systems for child care providers. Minnesota is developing an apprenticeship program for child care providers. Oregon set up a scholarship fund which supports provider training and accreditation.

- All States are financing consumer education activities. South Carolina's consumer education campaign includes a statewide "800" telephone number, brochures and videos for parents, and public services announcements on television and radio.

- States are supporting information, resource, and referral efforts to assist not just in parents' efforts to locate appropriate providers, but also in provider recruitment and training activities.

- States have begun creative efforts to address the critical issue of improving staff salaries and benefits.

- States such as Arizona, Arkansas, Maryland, Michigan, New Jersey, and Oregon are making substantial progress in their development of automated information and management systems which improve the coordination and delivery of child care benefits.

- Some States have increased the size of their monitoring staff; others are training their licensing staff on child development issues.

- States are funding programs for teen parents and linking child care to comprehensive service strategies. Oregon has provided start-up grants to local, school-based teen parent programs that offer parenting and child development classes, life skills training, and on-site child care.

- Special efforts have been made to improve the supply of quality infant care and care for children with special needs since these types of care are generally scarce, yet face an increasing demand. Maryland funds specialized training for providers who care for infants and toddlers with special needs.

While the Title IV-A child care programs do not include similar funding which directly supports quality improvement activities, IV-A administrative funds may be spent on activities that serve IV-A families, including: counseling of parents, resource and referral activities, training of agency staff on quality issues, and criminal background checks of potential providers who are not subject to licensure. In addition, CCDBG funds may be used to improve the care for children subsidized by the IV-A programs.

Along with these efforts by grantees, ACF has taken a number of steps over the past few years to help ensure the quality of care.

- We sponsored three National Child Care Conferences for State and Tribal child care administrators, Head Start program staff, educators, and child care advocates. Agenda topics included: 1) quality incentives for providers; 2) provider training; 3) consumer information; and 4) health links for quality. The third conference emphasized healthy child care and promoted health links. We also sponsored the first National Tribal Child Care Conference, which was attended by representatives from over 200 Tribes from across the country.

- We sponsored ten Regional symposia for State administrators and five Tribal workshops to provide training and technical assistance on a variety of topics including quality issues. These meetings included roundtable discussions on the use of quality improvement funds and funding for early childhood development and before- and after-school programs, as well as on consumer education services.

- We sponsored two Institutes based on requests from grantees for specific, in-depth discussions around selected topics. Our first focused on child care for infants and toddlers. Our second focused on State and community linkages around early-childhood programs.

- We collected information from the States on health and safety requirements and their use of funds from the 25 percent CCDBG set-aside towards expanding, establishing, and conducting early-childhood development programs and before- and after-school programs, as well as improving the quality of care.

Additionally, ACF is currently planning several activities including:

- An institute focusing on school-age child care.
- Two national meetings, one for State Administrators and one for Tribes.
- On-site technical assistance for ten grantees on a range on operational issues.
- Regional forums focusing on health and safety.
- A National Child Care Information Center to disseminate child care information, publications, and resources to grantees and the public.
- An Inter-Agency Agreement with the Head Start Bureau and the Maternal and Child Health Bureau to analyze

child care health and safety, licensing, and enforcement requirements and to convene a national child care health and safety symposium.

Conclusion

We have made important strides in recent years to improve the availability of quality child care. These efforts must continue. The Family Support Act of 1988 and the Omnibus Budget Reconciliation Act of 1990 were very important in establishing child care guarantees for certain families and providing substantial amounts of new Federal funding for child care services and quality. This Administration is dedicated to providing leadership to further improve the quality and accessibility of child care.

In closing, I want to again thank you for your interest and commitment to improving the lives of young children and their families through the provision of quality, affordable child care. I would be happy to answer any questions at this time.

Testimony to Sub-committee on Regulation, Business Opportunities and Technology
December 9, 1994

From: Janis Sabin Elliot, Administrator
Oregon Child Care Division

Representative Wyden and Members of the Sub-Committee:

Thank you for the opportunity to appear before the sub-committee today. I appreciate the concerns of this sub-committee regarding family child care and the importance of affordable, quality child care to the success of welfare reform initiatives. It is especially relevant that you are addressing family child care for it is often overlooked by policy makers. Family child care is an important and essential component of our envisioned comprehensive system of childhood care and education in Oregon. It is indeed a challenge, however, to develop reasonable strategies for enhancing the quality and increasing accessibility and affordability of care. We believe we've made commendable progress in Oregon and we have a long ways to go. Hopefully, the federal government will continue to be a partner with the states in these efforts.

Overview of State Involvement:

In Oregon, the focus of state government in child care is in three major areas:

1. **Childhood Care and Education Services to Low-income Families:** This is accomplished through the Oregon Pre-kindergarten Program which parallels the federal Head Start Program and subsidies to low-income working and student parents. The state also subsidizes the care of children from identified high-risk populations: children at risk of abuse and/or neglect, children of parents participating in substance abuse treatment, children of teen parents and children of migrant and seasonal agricultural workers. Approximately $90 million in state and federal funds are expended each biennium on these programs. While the bulk of financial assistance to parents comes from public funds, Oregon has a growing number of employers stepping in to the picture. Employers such as US Bancorp, Standard Insurance, ProTem and others have developed subsidy programs for those employees earning too much to qualify for state administered subsidies but still very strapped by child care costs.

2. **Regulation of Child Care Facilities**: In Oregon most child care centers and family group homes are licensed by the Child Care Division and family child care providers caring for more than three children from more than one family to whom they are not related must register with the Child Care Division. At this time there are slightly over 1000 licensed facilities and 12,000 registered family child care providers.

Approximately 90,000 children are cared for in these settings. The remainder are cared for in non-market arrangements, in settings exempt from regulation or in unlicensed and unregistered facilities. Currently, the state spends approximately $3 million a biennium, most of it state funds, on regulation.

3. **Development of the Infrastructure:** Oregon is building a community based system of child care resource and referral services providing services to families, child care providers, employers and communities. The resource and referral system is complemented by an extensive and comprehensive system of community planning and service delivery based in our 36 counties. Together the resource and referral system and the county commissions on Children and Families form the "backbone" of the system designed to make sure that families and children have access to the care that best suits their needs. Approximately $6 million (most of it from the Child Care and Development Block Grant) is spent each biennium on these activities.

In addition to increasing the supply of appropriate child care, Oregon is also building a comprehensive career development system to ensure the availability of qualified childhood care and education professionals. This plan addresses the training and compensation factors necessary to assuring quality care and education. The Child Care and Development Block Grant funds currently support most of these efforts although community colleges, universities, professional organizations and other workforce development resources are cooperating to build the needed system of training an education.

The best description of the state's involvement comes from "Estimating Child Care Needs in Oregon, 1993" published by the Oregon Commission for Child Care.

> "Most Oregon parents do not purchase supplemental care; they make a variety of arrangements, mostly within the family and without monetary exchange for services. When they do find child care in the wider community, they mostly pay for care themselves. Approximately 90% of the Oregon child-care market is family financed. The child-care "system" is not like the school system. With some exceptions we do not live in a society in which government creates the child-care programs and directs families to use them. Rather we live, work and arrange child care in a more or less free-market society in which government and community agencies can, at best, intervene in rather indirect ways to enhance the ability of families to make favorable choices. The community does indeed need to intervene in this way, because the child-care market, unassisted, doesn't work well enough. Large numbers of families report difficulty finding the kind of child care they want their children to have, and many parents experience stress in balancing work with their care giving responsibilities.
>
> As in other states, Oregon has adopted a policy of trying to improve child care by creating a network of resource and referral services as a focal point and community infrastructure for building supply, informing demand and analyzing emerging needs. This policy recognizes the need for a concerted and

> well-informed community effort. Parents, businesses, public employers, child-care providers, schools, churches, private agencies, foundations, and government all contribute to the development of a child care system. No one sector can do it alone. "

We have a theme for our efforts in Oregon, Child Care Works When We Work Together. This theme promotes the public and private partnerships necessary to achieve the goal of a comprehensive system of accessible, affordable and quality care.

Family Child Care

Family child care is essential to the achievement of our goals in Oregon. We estimate that approximately 86,000 children under the age of 13 are in family child care. Oregon's working families rely on family child care at least some of the time. In order to set priorities and assist in resource development, the Oregon Progress Board has established a benchmark measuring the availability of child care. According to the Oregon Child Care Resource and Referral Network, slightly over 30,000 family child care slots were known to the CCR&R system, meaning that we know little or nothing about the care received by the remaining 56,000 Oregon children. Prior to last August, we had no requirements for health and safety standards in family child care settings in Oregon. During the last session, the legislature required registration for any provider who cares for more than three children from more than one family, although even this requirement carries no inspection or assurance of compliance. The primary reason for passage of the new law was to increase the likelihood that resource and referral agencies, provider organizations, USDA food programs and government agencies could help providers access training and other forms of assistance. The registration is also intended to help parents find care and assist the state to assess child care supply and demand.

There are obvious gaps in the supply and demand of family child care. Some gaps are regional; some areas of the state have implemented recruitment strategies that come closer to filling the gap other areas are still unserved by child care resource and referral. Gaps also exist in the kind of care needed and available: shift-care, infant/toddler care, part-time care, before-and-after school care, sick child care are all difficult to find regardless of where one lives or what one earns. There is an affordability gap: 41% of Oregon's families earn less than $25,000 a year and the parent most likely to depend on paid care is a single mother with a child under age 5. She is also the least able to afford care, often paying as much as 20% of her household income on child-care. There is also a quality gap: with families stretched to the maximum handling child care fees, there is little room to implement the quality enhancing measures that assure healthy, safe and appropriate environments for many, if not most, of our children. The Oregon Progress Board is working with public and private child care partners, Families and Work Institute and AT&T Foundation to develop a quality benchmark that will help us measure our progress on improving quality in Oregon childhood care and education facilities.

Business Involvement

We are pleased with current business involvement in child care. Oregon has more small businesses per capita than any other state which makes the development of dependent care programs more challenging. Many have, however, risen to the challenge and developed programs, taking advantage of the business tax credit passed by the legislature in 1987. What is particularly relevant to the topic of discussion today is that the Business Tax Credit is very flexible, allowing a business to develop the dependent care assistance program that best fits their situation. Many businesses have, for example, established dependent care reimbursement plans which allow their employees to choose the type of care. Family child care arrangements are chosen by many families.

We are also pleased with the support Oregon is receiving from the corporate/foundation community in our efforts to build the child care system. Oregon is the recipient of grants from AT&T Foundation, the Child Care Action Campaign and Council of Chief State School Officers, the Northwest Area Foundation, Meyer Memorial Trust and numerous other corporate partners involved with the Oregon Child Development Fund. This support from outside the state as well as from within brings valuable support to our efforts.

Application to Other States

Let me say that I recognize Oregon has an advantage over some other states in addressing these issues. While our problems are daunting, they are not as severe as in some states. Our population is manageable in size, in fact it is possible for us to all know each other. We have a strong tradition of citizen involvement in decision making and we have had the blessings of strong, committed leadership in all branches of state government over the past several years. All that being true, there are many aspects of our experience that are applicable to other states. Amongst them are:

1. Incorporation of Family Child Care into Planning/Service Delivery Processes: In some of our counties, there have been grant writing workshops for family child care providers or other provisions in the funding process to encourage involvement of family child care providers. Our resource and referral agencies and state planning groups ensure family child care participation and we have dedicated funds to hire replacement care and assist with travel costs to make it possible for family child care providers to participate.

2. Community-based Planning: Nationally I see a growing interest in community based planning and we know that our experience in Oregon is applicable in most other places. When former House Speaker Tip O'Neill said politics is local, local, local, he could have well been describing childhood care and education. It is local, local, local. The role of state and federal government must be to set broad policy guidelines, ensure equitable distribution and access to resources and build common vision, but ultimately the families must be more involved in decision making and that happens best on the local level.

3. Good Data to Inform Decision Making: Every dollar that we invest in childhood care and education is precious, whether it comes from a parent, an employer, the government or a charitable organization. In order to ensure that those dollars are being well spent, we must have good data about the overall system, supply and demand and quality. While we get requests for information about a lot of what we're doing in Oregon, our Childhood Care and Education Data Project is the subject of the most requests. We have focused on a few key questions that we believe are essential to good decision making and put our efforts into answering them on the state, county and community level so that decision makers have access to the information they need. This is definitely applicable to other states and Oregon is working with national partners to help apply it on the national level as well.

4. State Support that Exceeds Federal Funds. Because of the commitment, leadership and vision, Oregon is investing a significant amount of state General Fund in all aspects of our system. We do not rely on the federal government to do it all. State dollars in the pre-kindergarten program, significant state general fund in the child care subsidy program and state funding for the resource and referral program have helped significantly. We could do even more if federal commitment matched the state commitment but it is essential to create state level ownership of these efforts if they are to succeed. We are very challenged at this point to maintain this level of state support due to state budget constraints.

5. Comprehensive CCR&R System: It is Child Care Resource and Referral that makes is possible to pursue the dual goals of our system: statewide consistency and equitability and local planning. Through the mandate of core service delivery in all areas of the state, CCR&R helps build the comprehensive system that includes the needs of all participants and delivers responsive services to families. CCR&R is important in all aspects of our endeavor but especially relevant in our efforts to link family child care providers into a system while still respecting the unique characteristics of each individual provider. CCR&R is also the most effective link between parents and family child care.

6. Common Goals and Values: We've worked hard to build a statement of common goals and values that transcends individual agencies and organizations. It takes work to develop such a statement and to put it into practice, but we're committed to doing that work and it serves us well. There is no reason other states can't do the same work and indeed many are.

7. Interagency Collaboration: Effective collaboration cannot take place without many of the above mentioned features but they don't assure collaboration. We are all indeed learning a lot about collaboration; what it is and what it isn't. A colleague from Ohio compared collaboration to teen age sex, saying that a lot of people are talking about it but fewer are actually doing it. We have some very effective collaborative efforts in Oregon and we're also learning from our colleagues in other states. Hopefully, our federal partners are also learning about collaboration, if we don't we're in trouble.

8. Make Private Investment More Attractive: Oregon has a business tax credit for dependent care investments by Oregon employers. Although not a significant factor financially, it has encouraged corporate involvement in developing solutions and I think that is important. The presence of Child Care Resource and Referral and community planning efforts have also made it easier for businesses to get involved, thus strengthening our partnerships.

Public/Private Sector Involvement in Family Child Care:

Largely as a result of the factors I mentioned above, we've had some exciting private sector involvement in family child care.

1. Support for Recruitment and Retention Projects: The Oregon Child Development Fund has been the conduit for numerous corporate and foundation contributions to training, recruitment and retention efforts. Tied closely to community planning and service delivery, generally with CCR&R, these funds have trained more than 2500 family child care providers and increased the supply of trained family child care in the state. As a result of coordination private sector contributions of any amount are combined to support initiatives that would not have been possible alone.

2. Support for Quality Initiatives: Private sector support for quality enhancement efforts has dramatically enhanced efforts in the public sector. Mervyn's and Dayto. Hudson through the Child Care Aware Campaign have partnered with the Child Care Division, the Oregon Child Care Resource & Referral Network and other private partnerships to increase parent awareness of quality indicators and assist parents to make quality choices for children. Oregon is also a partner with two major national initiatives, EQUIP (Early Childhood Quality Improvement Project) and Forging the Link that are models of private funders working with private nationally based organizations (Families & Work Institute, Child Care Action Campaign and Council of Chief State School Officers) and states and communities to implement quality enhancement strategies. National funds and technical assistance are brought to bear on the local level where change is the most possible.

3. Projects that Incorporate Family Child Care as an Option: We have several innovative projects that support family child care as an option: a) private child care centers are working with a network of family child care providers in the community to develop training options, diversify services to parents and build stronger links within the childhood care and education community. Penninsula Child Care Center and the Volunteers of America have worked with Multnomah County on these innovative projects; b) The Oregon Prekindergarten Program in Lane County recruited family child care providers to work with OPP staff in developing a family child care based Head Start services; c) Businesses providing subsidies to employees using Oregon's Business Tax Credit allow employees to choose family care as well as center based care.

Relationship to Welfare Reform

Our experience in Oregon can do much to inform the debate over welfare reform strategies. The progress we have made in building a comprehensive child care system over the last several years in Oregon has been achieved hand in hand with our welfare reform strategies. When Oregon began implementation of the Family Support Act in 1989, the Department of Human Resources made a clear commitment to working with the Commission for Child Care and the Child Care Resource and Referral agencies to build the child care system. As a result of our investments in self-sufficiency strategies and support for child care, Oregon has experienced a decline in AFDC caseloads and an increase in child care caseloads*. (*See attached charts) The state has more than tripled its expenditures for child care. Family child care is frequently the option, in fact 65% of Employment Related Day Care clients are using family child care. There are important considerations that come from our experiences thus far: You will note a striking similarity between these points and the points I mentioned previously regarding system development. Parents receiving welfare assistance are not different from other parents and the same principles that guide development of the childhood care and education system for Oregon's families apply to welfare reform strategies. It is just that some of them are even more important in the case of welfare reform. Just as we want parents to make good choices for their children and to be responsible consumers of child care, the state must make good choices for the well-being of children and be a responsible consumer of child care.

1. Consumer Education and Parent Information are Essential Components. Providing information to parents on how to select and maintain the most appropriate care for their children is key to ensuring child care options that work for the parent and the child. Disrupted child care placements affect work attendance and long term self-sufficiency. Disconuity of care is also the major factor influencing quality and the long term well-being of children.

2. The Subsidy Program must be as "Seamless" as possible In Order to Ensure Continuity of Care for Children and Stability for Families. If care arrangements must change as parents move into and out of the welfare system it is disruptive to children and does not provide adequate support to parents.

3. Direct Provider Payment has Proven a Major Mactor in the Willingness of More "Established" Child Care Programs to Care for Children on Subsidies. Prior to implementation of the direct payment system, families had trouble accessing programs that provided higher quality care because the program had little assurance of payment in a timely manner.

4. Payment at the Prevailing Market Rate is Essential to Assure Adequate Parental Choice and a Range of Quality Options for Children. Current market rates do not reflect the full cost of quality care because of the complexities of financing in the childhood care and education system. Providers are already subsidizing the cost of care in most circumstances with low wages and lack of benefits. If the state does not at least meet the prevailing market rate then higher quality programs simply cannot

afford to care for children on subsidies. Welfare reform is a two generation intervention and our strategies must address the needs of children for quality care and the needs of parents for child care that allows them to work and/or attend school.

5. It is also important that Child Care Policies in Welfare Reform Initiatives Support Efforts to Sssure a Bbasic Level of Health and Safety in Child Care Programs. Market forces alone will not insure quality, so there must be some provision for basic health and safety requirements. In Oregon, we have not found that our basic health and safety requirements have restricted parental access, although we attend carefully to the balance between higher standards and adequate supply.

6. It is Important to Allow Use of Federal Funds to Build the Infrastructure of the Childhood Care and Education System. Child care as part of a welfare reform strategy is not only the financial assistance to purchase needed care, it is also making sure that we can do supply-building and quality enhancement activities.

7. The System Must be "Family Fiendly". Making Every Effort to Remove the Stigma Associated with Welfare so that Families Can and Will Access Support Services Prior to Dependence on Welfare. In this way, we accomplish true "welfare reform", decreasing the need for welfare assistance in the first place. The partnerships between Adult & Family Services and the resource and referral agencies in Orego has done much to make our service delivery system more accessible to families.

8. Community Partnerships and Local Planning are also Important to the Success of Welfare Reform Wtrategies. As state agencies work with community partners to develop strategies, the community's investment increases and we can implement programs that help families succeed. If our work isn't grounded in the community, then it is too easy to shift the blame and the responsibility instead of recognizing that we're all in this together.

One other point that I wish to raise in regards to welfare reform. President Clinton has proposed reductions in the USDA child and adult food program to finance welfare reform and there have been proposals from the new Republican leadership to create "block" grants of nutrition programs. Although not often discussed, the USDA child care food program is one of the most important means of improving the quality of care in family child care settings. Changes in that program must be considered carefully lest we diminish the quality of care in the process. We are just beginning to explore the ways in which the food program sponsors can be even more involved in helping us achieve our goals for family child care in Oregon. It would be, I think, penny wise and pound foolish to eliminate this program in order to fund welfare reform.

EMPLOYMENT RELATED DAYCARE
BASIC & TRANSITIONAL CASES

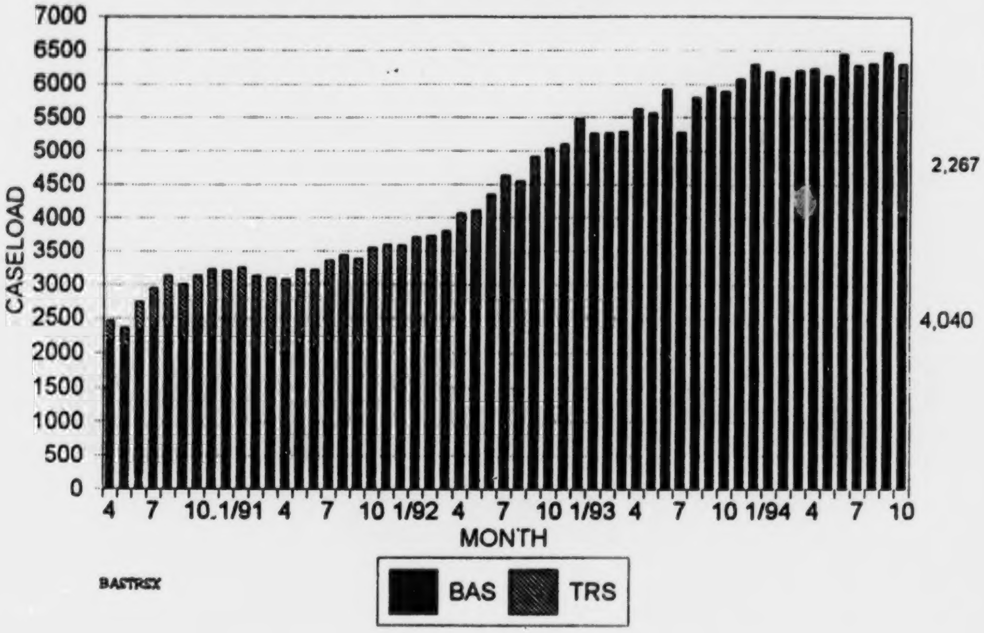


CHART IV

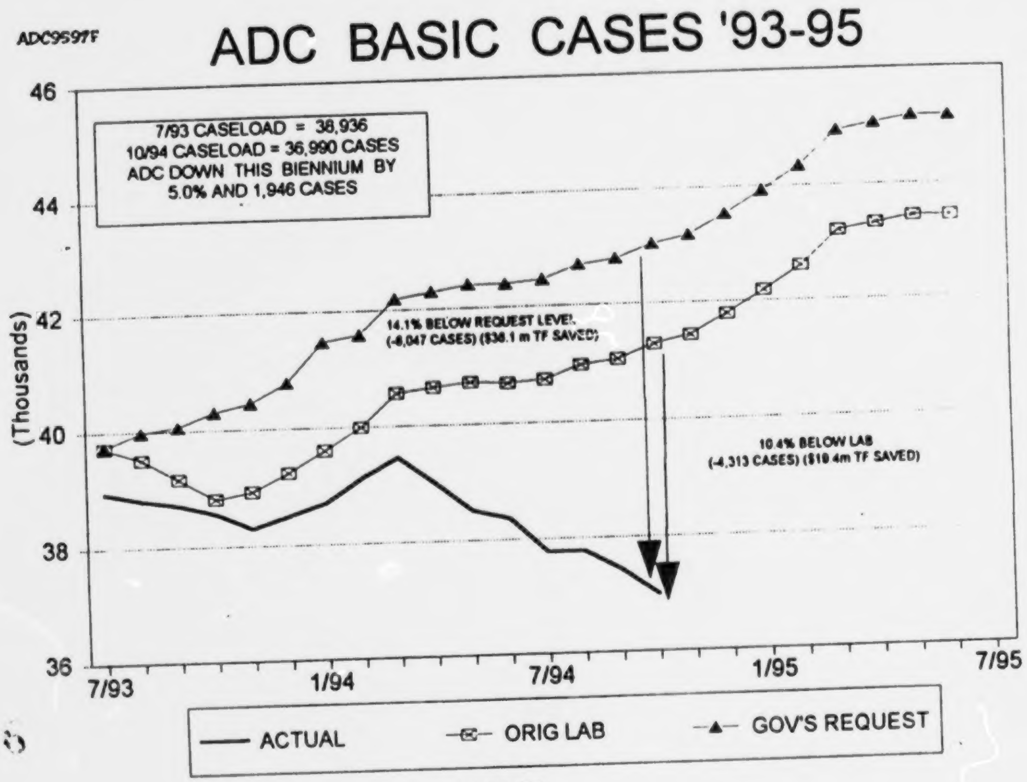

ADC9597F
ADC BASIC CASES '93-95
7/93 CASELOAD = 38,936
10/94 CASELOAD = 36,990 CASES
ADC DOWN THIS BIENNIUM BY
5.0% AND 1,946 CASES
14.1% BELOW REQUEST LEVEL
(-6,047 CASES) ($36.1 m TF SAVED)
10.4% BELOW LAB
(-4,313 CASES) ($10.4m TF SAVED)
(Thousands)
46
44
42
40
38
36
7/93
1/94
7/94
1/95
7/95
ACTUAL
ORIG LAB
GOV'S REQUEST

CHART VI

Testimony of Margaret Ragan
Hearing of the House Subcommittee on Small Business, Regulation, Business Opportunity, Technology
December 9, 1994

When my first and only child, a daughter,was 6 weeks old, I returned to work full time. I worked for a company that paid well, offered paid medical benefits, and was paying for my college education. My husband also worked fulltime.

We spent weeks looking for a home child care provider. Articles we had read recommended a home environment for infants as opposed to a child care center. We found the individual we felt comfortable with. She was registered with the State, was signed up with the USDA food program, and stated she was certified in CPR and first aid. We called references she provided us with. All of the recommendations were good or great. We asked questions provide to us by a local referral agency. We felt we had covered all the bases.

At 9 months old, my daughter was not yet crawling or walking, in other words not mobile. On September 3, 1992 I drove to the provider's home to pick up my daughter. When I arrived I found my daughter fussing and obviously in some discomfort. The provider explained to me that my daughter had bumped her head earlier in the day - around noon - and had been fussy and not slept since then, it was now 5:30pm. She had not found a bump on her head but had iced it just the same. I carried my daughter to the car and attempted to put her in her car seat. She began crying very hard. Each time I tried to set her in her seat she cried louder. I finally asked another parent to drive us home. Before we had reached my home I had determined by lifting her right leg that something was wrong with her leg and not her head. My husband and I rushed her to the hospital. She had a spiral fracture of the right femur. A spiral fracture is an injury which occurs as a result of a twist. She was placed in a cast, hospitalized overnight, and sedated with demerol every 1-2 hours throughout the night.

An investigation was done. The witnesses were the provider's husband and mother-in-law, in other words, no witnesses. The police department explained that they were sorry, but there was no way to determine that it was anything more than an accident. The provider had no liability insurance, so we hired an attorney to help us collect medical expenses.

In a worst-case scenario, my daughter could have been left with one leg longer than the other, but she is fine. She is 3 years old now and capable of talking and telling me about her day. I've spent the past two years home with her. I provided child care during this time in order to provide the necessary second income for our household. I have recently begun working outside of my home, part-time.

The problem with home child care is multifold. Specifically, there is no one to check these homes. During my two years as a registered provider, no one from Children's Services Division ever stopped by to inspect my home. There is no competency testing or educational requirements to become registered. Providers are not required to carry liability insurance. I hope this can be changed, so that another family may not have to live through my worst nightmare.

Hearing on Family Child Care
Subcommittee on Regulation, Business Opportunities, and Technology.
Committee on Small Business
United States House of Representatives
Portland, Oregon
December 9, 1994

I am Jeannie Suihkonen, a 35 year old Family Child Care Provider living in Salem, Oregon. For as long as I remember I have looked forward to being a parent. My husband and I are now raising two children, and eight year old and a five year old. It is as rewarding and magnificent as I always thought it would be, while being more challenging and frustrating then I imagined.

Prior to my work in Family Child Care, I had a career in Dental Assisting for eight years. In 1987 when my daughter was one year old, I decided to stay home but needed an income. Family Child Care seemed like a perfect blend of the two. I provided child care for one year and quit. I was miserable. I had no support for my work as a Family Child Care Provider and went back to dental assisting. In 1989 my second child was born. I met a neighbor who was doing Family Child Care and she gave me some information on professional support groups for providers. I really wanted to be with my children so I decided to try Family Child Care again. I joined Salem Home Child Care Association and learned about new classes being offered at our local community college for Family Child Care Providers, called Family to Family. This class was packed with resources and information, exactly the piece that was missing for my success. I learned how to write business contracts, work together with parents, where to find first aid and CPR classes, and why it was important for me to take them. I also received information on child development, planning activities, children's environment, guiding children, keeping business records, health and nutrition, community resources and much more. I took this new awareness home and put it to work immediately.

These classes began a commitment for me to grow professionally. I strongly believe that if more training opportunities like Family to Family were available at an affordable rate, especially for people just starting out, this by far would increase the quality of Family Child Care, job commitment, self-esteem of Family Child Care Providers, and contribute directly to the length of a provider continuing with this business.

I know that providers who have a sense of commitment and are intentional in their approach are more likely to provide quality child care. For those who don't receive the "missing piece" for their business, we will never know the positive contribution that might have been.

In 1993, I was elected Co-President of Salem Home Child Care Association. I am now chairperson for an Oregon Association for the Education of Young Children (O.A.E.Y.C.) task force to begin a Family Child Care Network in the state of Oregon. Though the network is in the infancy stages, we are hoping this will be a direct line of communication for information exchange from the state to Family Child Care Providers and vice versa. I feel that some great things are happening in Oregon for Family Child Care and it can continue to grow and will only improve Oregon now and in the future. Awareness brings knowledge, knowledge is education, from education comes professionalism, and professionalism brings quality. This is something we all want for our children.

If we want quality Family Child Care we have to continue to offer education specifically designed for Family Child Care Providers, and offered at hours that Family Child Care Providers can attend without interfering with business hours, and at an affordable rate.

Taking Family to Family classes was the beginning of professionalism for me. I know I would not still be in this field if this information was not available to me. I have been successfully providing child care for five years now and I received my National Family Child Care Child Development Associates (C.D.A.) Accreditation in October, 1992. I am committed to seek training and new information regarding child development and quality Family Child Care procedures. I will continue to do so as long as they are available to me.

Hearing on Family Child Care
Subcommittee on Regulation, Business Opportunities, and Technology, Committee on Small Business
United States House of Representatives
Portland, Oregon
December 9, 1994

I am Bobbie Weber, Chair of the Department of Family Resources, Linn-Benton Community College, Albany, Oregon. I also represent the Oregon Community College Association, the Oregon Child Care Resource and Referral Network and the National Association of Child Care Resource and Referral Agencies (NACCRRA) of which I am the President. Oregon has been a leader in state and national efforts to improve the quality of child care. I am here today to share relevant findings and recommendations.

Access to affordable, quality child care is beyond the grasp of the majority of families in Oregon as in the rest of the nation. If the child is in the first, most formative years of life, parents face the greatest challenge in finding good care and the child faces the greatest risks to healthy development. Changes in the American economy have led to at least two critical realities: the majority of families need both parents employed in order to meet basic needs and the national economy needs the participation of females of child bearing age in the workforce. These changes mean that families need support in raising their children. America's well-being is dependent on our ability to support families' efforts to nurture their own children by insuring them access to affordable, quality care.

Years of research have resulted in consistent findings on what in child care predicts positive child outcomes. For family child care the predictors include a cluster of related provider behaviors: they get regulated, get support and participate in child care related training. Community systems are essential to support provider efforts to improve the quality of the care they give. Regulation must be in place, provider associations and child care resource and referral agencies must be there ready to support providers and a stable system of accessible, affordable training must be institutionalized. Local communities , the state and federal government must work in consort in order for providers to have access to basic services which we know lead to the provision of quality care. Foundations, corporate and other private sector leaders provide leadership and often resources to begin new initiatives.

Since 1988, Oregon has been involved in a number of initiatives that have dramatically improved families' access to quality child care. These initiatives model state and local coordination and public/private partnerships. In addition Oregon is involved in a number of efforts to work cooperatively with national and federal quality initiatives. I will briefly describe a number of them and then detail lessons learned.

Quality initiatives began with Oregon's selection in 1988 as one of the first sites of *Family to Family*, a family child care training, accreditation and consumer education project of the Dayton-Hudson companies. Through this partnership with Oregon Community Colleges, training was integrated into higher education, numerous provider organizations emerged, over 600 providers received training and numerous consumer education efforts were launched. The designers of *Family to Family* knew that to increase quality both providers and parents needed to be reached. If parents don't know what to look for and don't believe they have choices, quality improvements by providers will not be sustained. Therefore, Mervyn's partnered with child care resource and referral agencies and targeted parents. *Child Care Aware* , the consumer education project which grew out of *Family to Family*, uses a multi-media strategy to educate parents about quality.

In 1989 Ford Foundation support led to the institutionalization of both a statewide system of child care resource and referral agencies(CCR&Rs) and a fund dedicated to improving quality in care within the Oregon Community Foundation, the Oregon Child Development Fund(OCDF). Both CCR&Rs and OCDF continue to work together and with numerous other partners including associations of family child care providers and foundations such as the Meyer Memorial Trust to insure that providers have access to support and training.

A partnership of organizations committed to the improvement of child care have worked together since 1989 on documenting, analyzing and reporting the status of child care. The Aspen Institute, Meyer Memorial Trust and now the Families and Work Institute and AT&T Foundation have supported Oregon's Childhood Care and Education Data Group's efforts to benchmark progress in improving care. The newest effort, the *Early Education Quality Improvement Project* (EQUIP), will bring parents and corporate representatives into leadership positions as we

BEST COPY AVAILABLE

document the quality of existing care and measure our efforts to improve it. Through the EQUIP Project and its linkage with NACCRRA, Oregon has been a part of The Early Childhood Data Collection Group led by NACCRRA, the Families and Work Institute and the Women's Bureau. The Data Group is a partnership of the federal government, researchers and local communities committed to developing the consensus on data elements necessary to enable meaningful measurement of quality. Measuring progress is essential to community efforts.

Subsidies for care are a critical component of any strategy to get and keep families off welfare. Oregon has been successful in reducing AFDC roles and believe the dramatic increases in enrollment in the subsidy program is one of the key strategies leading to this success. Stephen Minnich, one of the state administrators involved in developing the "Oregon Option", was quoted as saying that shifting money into child care will help the state continue its current success in lowering welfare roles.

The partnership of Adult and Family Services and the state CCR&Rs is key. The federal role in the development of this partnership was critical and can provide guidance to future welfare reform efforts. With the passage of the Family Support Act, Oregon welfare administrators came to local communities to understand the child care crisis that threatened the success of the new JOBS program. In 1992 Adult and Family Services piloted a partnership with Oregon's child care resource and referral system in four communities. This partnership greatly improved the effectiveness of the subsidy program and was implemented statewide in July, 1993. Parents need a variety of help to make it in the paid workforce. They need help finding and identifying quality care and they need to know that they have child care options. A significant finding from the evaluation of the Pilot Projects was the increase in parents' selection of regulated providers. A study prior to the Pilots found that 28% of the providers chosen by parents were regulated. In the Pilot areas that increased to 55% although informal care remained a valid choice. Through the partnership with the CCR&Rs parents found they had options and were given the consumer education and support and support needed to make use of these options.

Passage of the Child Care and Development Block Grant (CCDBG) is another example of the role the federal government can play in strengthening state effort. In Oregon CCDBG advanced state efforts to become a solid partner with communities and private funders in efforts to improve access and quality. The quality set-aside is leveraging CCR&R services, training and support of associations; all efforts essential to improving quality. The strong partnership with the welfare agency has brought all these efforts into synch with the subsidy program. The proposed federal child care revisions will further support these combined efforts.

The following are some of the lessons Oregon has learned:
1. No one sector can do it alone. Federal and state government need to partner with parents, providers, CCR&Rs, local communities, the corporate sector and private funders, multiple state offices and policy makers.
2. The State needs a shared vision and principles to bring the diverse players together in one effort. Stakeholders need to know the current status of the amount and quality of care and be able to benchmark progress toward agreed upon goals.
3. Leveraging can lead to institutionalization of needed services
4. Subsidy systems have the power to impact quality in ways far greater than by care actually funded.
6. All subsidy programs need to take into account their impact on quality and look for ways to use them to improve quality.
7. High levels of turnover continue to threaten the well-being of children.
8. Turnover is closely aligned to low wages.

A multi-pronged effort involving parents, providers, CCR&Rs, local communities, private foundations, corporations and state government is necessary to lead to the changes needed to improve quality. Any effort to reform welfare must take into account the need of both AFDC and working poor families for access to quality care. Subsidies are one piece of a broader strategy that includes training, child care resource and referral and regulation. Quality options have to be available. Basic protection must be assured. Parents need to have informed choices. As Oregon leaders have indicated, child care is key to success of welfare reform efforts. The Federal government has the opportunity to work closely with states so that limited federal dollars will have major positive impacts.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Refer to: MCR-C-SLB

Region IX
75 Hawthorne Street
San Francisco, CA 94105

Sushil K. Sharma, Ph.D, Dr.PH
Assistant Director
Program Evaluation and Methodology Division
United States General Accounting Office
441 "G" St. N.W., Room 5737
Washington D.C. 20548

RE: GAO Testimony: "Inconsistent Denial Rates for Medical Necessity Across Six Carriers"

Dear Dr. Sharma:

Enclosed is the report compiled by Transamerica Occidental (TOLIC) in response to testimony presented to the U.S. House of Representatives on March 29, 1994 on Medicare carrier denial rates. We appreciate your allowing the carriers in California the opportunity to provide information and comments for your final report.

Throughout the TOLIC detail report, you will find references to GAO claims data. For your information, this refers to claim control numbers for specific codes our office requested from the same data you received from BDMS. We were attempting to verify if there was a reporting problem from the carrier to the proper category in the Common Working File. We did not obtain data for all the CPT codes studied by GAO. Our focus was primarily the evaluation and management codes for which limited medical necessity denials should have been reported in 1992.

We are coordinating with our Central Office staff on those issues which TOLIC indicated need further clarification.

If you have any questions regarding TOLIC's report, please feel free to contact either Sharon Burgess or me at (415) 744-3643.

Sincerely,

Alysson Blake, Chief
Contractor Operations
Division of Medicare

Enclosure

cc George Garcia
Transamerica Occidental

TRANSAMERICA
OCCIDENTAL LIFE

GEORGE E. GARCIA
Vice President
Chief Medicare Officer

Transamerica Occidental
Life Insurance Company
Transamerica Center
1150 South Olive
Los Angeles, CA 90015-2211
Mailing Address
P.O. Box 5072
Upland, CA 91785-5072
(213) 742-2561

May 31, 1994

Sushil K. Sharma, Ph.D, Dr. PH
Project Director
United States General Accounting Office
Washington, DC 20548

RE: General Accounting Office (GAO) Testimony:
"Inconsistent Denial Rates for Medical Necessity
Across Six Carriers"

Dear Dr. Sharma:

We at Transamerica Occidental Life Insurance Company, one of the carriers in your study, appreciate the opportunity to respond to the finding of the GAO testimony on inconsistent denial rates for medical necessity presented to Congress on March 29, 1994. As the Medicare Part B carrier in Southern California, it is our role to uphold and implement the Medicare guidelines and policies that have been established by the Health Care Financing Administration (HCFA).

There is no financial incentive for Transamerica Occidental to reject claims. Medicare is a government program funded with taxpayer's dollars, and it is our responsibility to administer the program diligently. It is a responsibility we take very seriously.

Attached is an analysis of claim data on 17 Medicare procedure codes that were found to have variances in denial rates among the six carriers studied. A summary and detail of our analysis is attached to this letter. I would, however, like to encapsulate our findings.

Seven procedure codes denied for medical necessity fell within HCFA mandated parameters, including Physician Payment Reform and rebundling edits.

> For example, the GAO report noted our operation denied claims for percutaneous transluminal coronary balloon angioplasty (procedure code 92982) more often than other carriers. With the implementation of Physician Payment Reform in 1992, restrictions were set to disallow payment for an assistant surgeon during this procedure. Analysis of the GAO claim data reflected 90% of the medical necessity denials were for assistant surgeon claims. Carrier data for April to October 1992 also supports this fact. The large denial rate was due to the change in HCFA policy. Analysis of 1993 data indicates a decrease in billings for assistant surgeons.

BEST COPY AVAILABLE

Three procedure codes were denied and reported under an improper classification of denial codes. In these cases, the claims should have been denied because the service was not covered, not for medical necessity.

As an examplé, the entire ambulance criteria (procedure codes A0010 and A0020) were reviewed in 1993, and instructions were clarified. Changes were made to the reporting classification of messages as a result of our review of the Medicare Coverage Manual. Some denials were shifted from a medical necessity classification to a coverage classification. This reporting had no impact on the outcome of the claims. Because of variation among carriers for this and similar procedure codes, there needs to be more definitive information from HCFA as to how the claims should be classified.

Three of 17 procedure codes were denied because of billing problems, including poor descriptor of codes, classification of diagnostic versus screening tests, and multiple billings of the same service.

For example, bilateral mammography (procedure code 76091) claims were denied because of medical necessity, i.e., the diagnosis did not support the service. The claims did not support a *diagnostic* mammography, which is performed in the presence of a palpable mass or other symptomatology. However, the claim information did support a *screening* mammography. If these claims had been submitted as screenings claims, and if they had met all other criteria, they would have been paid.

Four procedure codes were validated on the basis of medical necessity.

As an example, analysis of internal and national claims data on manual manipulation of a spine by a chiropractor (procedure code A2000) indicates our denial rate is within national averages. Regional differences are similar. The high volume of denials is reflective of maintenance therapy and not for improvement of a malfunctioning body member. Maintenance therapy is not covered under the Medicare program.

Review of similar data for fiscal year 1993 shows most variances no longer exist, and our denial rates are within national averages.

If you should have any questions about the analysis or need additional information, please call me at (213) 742-2561.

Sincerely,

George Garcia
Vice President
Chief Medicare Officer

Transamerica Occidental Life Insurance Company
Medicare Administration

SUMMARY OF ANALYSIS

A0010 Ambulance base rate, basic life support
A0020 Ambulance service, (BLS) per mile

The entire ambulance criteria were reviewed in 1993, and instructions clarified. Changes were made to the reporting classification of messages as a result of our review of MCM coverage criteria, shifting some of the denials from a medical necessity classification to a coverage classification. This reporting change had no impact on the outcome of the claims.

The MCM specifies that transportation must be to the nearest appropriate facility. Within Transamerica's service area, there are large metropolitan areas with an abundance of hospitals. We have established a point at which additional information will be required. For the major metropolitan areas, it is beyond 15 miles. For more rural areas, it is 40 miles. Transportation beyond these limits generally only becomes a problem for "return" trips from a hospital setting, as does the transportation itself. Focused studies are being conducted on ambulance services this fiscal year.

There is a great deal of variation among carriers as to whether certain types of ambulance denials are based on medical necessity or coverage. There needs to be more definitive information from HCFA as to how they want the denials to be classified.

A2000 Manual manipulation of spine by Chiropractor

Analysis of internal claims data, as well as the national (BESS) data, reflects that Transamerica is in line with the national averages. Regional differences are also minimal, suggesting that carrier policies are similar. The high volume of denials is reflective of maintenance therapy, and not for improvement of a malfunctioning body area. Maintenance therapy is not covered under the program.

66984 Cataract removal with insertion of IOL

Analysis of the data reflects a billing problem during 1992 based on the new global surgery policies under Physician Payment Reform. Physicians failed to utilize the appropriate modifiers, resulting in additional surgeries (ie, second eye, YAG laser, etc.) within the postoperative period denied as part of the postoperative care. Based on carrier data for April to October, 1992, these denials were classifed as medical necessity, when they should have been classified as coverage denials. This incorrect classification accounted for 96.6% of the medical necessity denials, but did not affect the outcome of the claims. A comparative analysis of 1992 to 1993 data suggests an increased understanding of billing requirements for global surgery.

71020 Chest x-ray, two views

Transamerica had no formal diagnosis policy in 1992. Claims were reviewed for indications of screening (asymptomatic patients). A focused study in 1993 indicated that 33% of the claims submitted were for screening or routine examinations. Diagnostic critaria was established in conjunction with the medical community.

There is a continued trend toward diagnostic screening for asymptomatic patients which we feel necessitates a formal policy. There is also wide variation among carriers as to the necessity for pre-operative diagnostic testing, and whether it falls within the "medical necessity" coverage of the program. Review of various carriers' policy indicates that some deny services outside their coverage criteria as "routine physical examination", and not as a medical necessity denial. HCFA needs to clarify their position on this issue so there is more consistency on a national basis.

76091 Mammography, bilateral

Diagnostic criteria was developed prior to implementation of national coverage for screening mammograms as a result of physicians billing for screening tests. Diagnostic criteria has been revised as a result of a focused study, but analysis of carrier and GAO claim data reflects that the conditions billed did not support a diagnostic (based on patient symptoms or complaints) mammography. Rather, the diagnoses were indicative of screening. Physicians who are not certified as screening mammography centers cannot use the screening mammography codes, based on specific HCFA coverage criteria for screening. If these services had been performed by a screening mammography center using the HCFA coverage guidelines, they would have been allowed.

HCFA needs to re-evaluate its screening mammography billing and coverage requirements. Many screening services are being performed by non-screening centers under the non-screening procedure code. This may reflect a lack of, or inaccessibility to, screening mammography centers.

There are also differences among carriers as to what constitutes a screening test. Some of the encounter codes used by HCFA as an indication for screening are also being used for diagnostic tests. Further clarification is needed.

88305 Surgical pathology

Prior to 1992, there was considerable confusion on how to bill for surgical pathology codes because of the descriptors. This led to overuse of the code. The descriptor changed in 1992. As a result of this change, and in cooperation with the medical community, an extensive analysis was made of the use and proper billing. Billing instructions were clarified to the community and revisions were made to internal processing to reduce suspensions and subsequent denials due to billing problems. These efforts have lessened coding confusion.

Utilization of this code is high compared to national data, but was explained and justified in a 1993 focused study based on the high incidence of solar related skin disease in Southern California. The billing problems are no longer apparent.

92982 Percutaneous transluminal coronary angioplasty (PTCA)

Billing and coverage criteria was developed for this procedure based on its sometimes questionable use when it was developed. Transamerica's policy was also to allow for an assistant surgeon.

In 1992, Physician Payment Reform (PPR) set a restriction on payment for an assistant-at-surgery. Analysis of the GAO claim data reflected that 90% of the medical necessity denials were for assistants-at-surgery. Carrier data for April to October 1992 also supports this fact. The large denial rate is due to a change in HCFA policy.

Pre-payment screens for PTCA were discontinued in 1993 due to improvements in billing. Comparision of the data to current practice indicates a decrease in billings for assistants, and no other evident problems.

93307 Echocardiography

Medical necessity criteria was developed in 1990 as a result of a questionable pattern of billing for asymptomatic patients (screening).

Analysis of the GAO claim data reflects that there was a problem with billing in 1992 by some physicians. Some providers did not avail themselves of the Appeal process and continually resubmitted denied services. Thirty-one percent of the patients accounted for fifty-one percent of the medical necessity denials. This indicates a pattern of physicians billing for the same service multiple times without additional documentation, resulting in the same service being denied again. These "rebillings" ranged from two to nine rebillings for the same date of service.

Analysis of 1993 HCFA data reflects that there is an aberrancy in allowed charges and services per 1000 beneficiaries for this service performed by Independent Physiological Laboratories. A focused study will be conducted this year, which will include review of accepted diagnostic criteria.

93320 Doppler Echocardiography

Medical necessity criteria was developed in 1990 as a result of a questionable pattern of billing for asymptomatic patients (screening).

Analysis of GAO data and carrier data correctly reflects the carrier policy of denial for indications not deemed medically necessary. The July to December, 1993 national data reflects no aberrancy in allowed charges or services per 1000 beneficiaries, or in overall denial rates, by cardiologists, the specialty that would primarily perform these tests. The problem of high denials are with other specialties. Many of these denied tests are interpretations performed on hospital inpatients or outpatients. This may indicate that there is a lack of communication from the ordering physician as to the indication or symptoms for which the test was ordered.

Transamerica will continue to advise physicians ordering tests of the need to provide enough information on their orders to enable interpreting physicians to bill properly. We will also evaluate our diagnosis criteria to determine if current practice would affect the allowable conditions.

93880 Duplex scan of extracranial arteries

Diagnostic criteria was developed for this code because of abuse dating back prior to 1986. We have worked with an Ad Hoc committee from the medical community to develop criteria that would reflect community practice for medically necessary services. Analysis of the data reflects the carrier policy of denial for non-medically necessary services.

An evaluation will be conducted of the diagnosis criteria to determine if any changes in current medical practice will affect the coverage determination.

99222	Initial hospital care
99231	Subsequent hospital care, problem focused
99233	Subsequent hospital care, detailed
99238	Hospital discharge day management
99283	Emergency department visit
99332	Domiciliary or rest home visit

The above Evaluation and Management (E&M) codes became effective January 1, 1992 and replaced the codes previously used to bill physicians' visits. Carriers were instructed to remove any medical necessity editing with the exception of concurrent hospital care review. HCFA also implemented visit code bundling edits, which limited the number of visits by the same physician on the same day to one E&M code.

Analysis of the GAO data reflects that 78% of the services denied for medical necessity were actually denied based on HCFA's rebundling edits. The messages sent to the beneficiaries and physicians were correct, but were classified incorrectly for reporting. This did not affect the outcome of the claims.

DETAIL ANALYSIS

A2000: Manipulation of spine by Chiropractor

Historical: HCFA has a mandated utilization edit for suspending services for further review. Transamerica established review criteria which allows for additional manipulations if exacerbations occur or certain conditions are met. Manipulations for chronic conditions, or maintenance, are not covered.

HCFA has also defined very specific billing requirements.

Community Notice: Articles were published on chiropractic coverage in Special Medical Policy Issue dated June 1989, September 1990, September 1991; Medicare Billing Manual dated 1992 and 1993; Your Medicare Newsletter issues #66 dated March 1991, #70 dated June 1992; and in a Special Notice to Chiropractors dated April 1992.

Current: Basic criteria has changed very little over the years. The existing utilization edits show a very low cost/benefit ratio for review. We are looking at ways to streamline the billing and processing requirements within the mandates of the MCM and Congressional intent.

Analysis: The BESS data for 1993 (downloaded from HCFA) reflects that there is no aberrancy for allowed charges or services per 1000 beneficiaries.

We did not download carrier data for this code because the BESS data reflects that there is not a problem. The overall denial rate is also within national averages and based on the numbers, our policy is very similar to other regional carriers.

GAO Claim Data: Analysis of 10 beneficiaries' claims showed all services were denied for medical necessity (diagnosis does not support the service; information does not support the frequency). Many of the beneficiaries were receiving weekly manipulations for many months, and sometimes years. These are considered maintenance therapy.

Conclusion: Data reflects that our coverage and payment policies enable Transamerica to remain within national averages.

A0010: Ambulance Service, basic life support (BLS), base rate, emergency loaded, one way

Historical: The Medicare Carriers Manual outlines specific criteria for ambulance transportation coverage. One criterion specifies that transportation is covered if movement by other means is contraindicated or would endanger the patient's life or health. Within HCFA's guidelines, Transamerica has established billing instructions indicating the types of conditions which warrant coverage. Claims submitted outside these parameters would require further documentation.

Community Notice: Articles were published on ambulance in the Special Policy Issue dated June 1989, September 1990 and September 1991; Your Medicare Newsletter issues #60 dated July 1989, #67 dated June 1990, #67 dated June 1991 and #68 dated September 1991; and the Medicare Billing Manual dated 1992 and 1993.

Current: The entire ambulance criteria were reviewed in 1993, and instructions clarified. It was determined that some denials were really program coverage denials, and not medical necessity. The Medicare Carriers Manual (MCM) requires that the patient be transported to the nearest appropriate facility. Denials for services that did not meet this requirement were previously reported as medical necessity denials. Changes were made to the reporting of various action codes, based on this assessment.

There has also been a concern expressed internally about documentation from ambulance companies that is almost exactly the same for multiple beneficiaries. Focused review studies and some provider audit cases have also been scheduled for this fiscal year.

Analysis: There is no BESS (HCFA) data available. Analysis of the April to October 1992 carrier data reflects that denials based on medical necessity (The patient could have traveled another way) were ranked third after entitlement and duplicate billings. However, these denials should be classified for reporting as coverage denials, as the patient's health would have allowed for other means of transportation. Analysis of the April to October 1993 data reflects the same pattern and classification problem.

GAO Claim Data: There was no data provided.

A0010 continued:

Conclusion: Transamerica will update the reporting classifications for the next quarterly reporting period. We will also complete our focused studies and provide more detailed information to the medical community on ambulance transportation issues.

There is also a great deal of variation in interpretation among carriers as to how denials should be made, and what constitutes a coverage denial versus a medical necessity denial. There needs to be more definitive information from HCFA as to how they classify denials based on the information in the Medicare Carriers Manual (MCM).

A0020: Ambulance service, (BLS) per mile, transport, one way

Historical: The Medicare Carriers Manual outlines specific criteria for ambulance transportation to be covered. One criterion specifies that transportation must be to the nearest appropriate facility. Transamerica has established basic mileage criteria for ambulance services. In metropolitan areas, services exceeding 15 miles require additional documentation. In rural areas, we allow 40 miles before requiring additional documentation.

Community Notice: Articles were published on ambulance in the Special Policy Issue dated June 1989, September 1990 and September 1991; Your Medicare Newsletter issues #60 dated July 1989, #67 dated June 1990, #67 dated June 1991 and #68 dated September 1991; and the Medicare Billing Manual dated 1992 and 1993.

Current: The entire ambulance criteria were reviewed in 1993, and instructions clarified. It was determined that some denials were really program coverage denials, and not medical necessity. The Medicare Carriers Manual (MCM) requires that the patient be transported to the nearest appropriate facility. Denials for services that did not meet this requirement were previously reported as medical necessity denials. Changes were made to the reporting of various action codes, based on this assessment.

A current study is being performed on our mileage policy. When compared to carriers nationwide, Transamerica has more urban areas, and very few rural areas which would warrant long transports. Preliminary analysis indicates that it is hospital discharge mileage that often exceeds the basic mileage, and not transportation to the hospital.

There has also been a concern expressed internally about documentation from ambulance companies that is almost exactly the same for multiple beneficiaries. Focused review studies and some provider audit cases have also been scheduled for this fiscal year.

Analysis: There is no BESS (HCFA) data available. Analysis of the April to October 1992 carrier data reflects that the primary denial was reported as a medical necessity denial (Information does not support ambulance service). However, this denial should be reported as a coverage denial, as the excess mileage was for transportation beyond the nearest appropriate facility. Analysis of the April to October 1993 data reflects the same problem.

GAO Claim Data: Analysis of 10 beneficiaries' claims showed all services were denied with the same action code that was reflected in the carrier data as being reported incorrectly.

A0020 continued:

Conclusion: Transamerica will update the reporting classifications for the next quarterly reporting period. We will also complete our focused studies and provide more detailed information to the medical community on ambulance transportation issues.

There is also a great deal of variation in interpretation among carriers as to how denials should be reported, and what constitutes a coverage denial versus a medical necessity denial. There needs to be more definitive information from HCFA as to how they classify denials based on the information in the MCM.

66984: Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)

Historical: There were no medical necessity edits for this procedure in the past. The Peer Review Organization (PRO) approved coverage for assistants-at-surgery for this procedure.

Community Notice: ' Articles were published on cataract removal, assistant surgeons, and/or global surgery policy in Your Medicare Newsletter issues #63 dated May 1990, #69 dated February 1992, #70 dated June 1992, #71 dated September 1992, #72 dated January 1993, #73 dated March 1993, #74 dated July 1993, #75 dated September 1993, #76 dated January 1994, #77 dated March 1994; and Medicare Billing Manual dated 1992.

Current: The PRO stopped pre-authorizing assistants as of December 31, 1992. This procedure is now on the national (5% restricted) list for non-payment of assistants.

Analysis: The BESS data for 1993 (downloaded from HCFA) reflects that there is no aberrancy for allowed services or charges per 1000 beneficiaries.

Analysis of the April to October 1992 carrier data reflects that medical necessity denials were 9.5% of the total services denied. Of this amount, 96.6% (719 of 737) were reported incorrectly. The message used (This service included in the pre-or post-op care) was correctly related to the physicians and beneficiaries, but incorrectly classified for reporting as a medical necessity denial. It should have been classified as an "other" denial, based on the global surgery policy. These denials generally reflected billings for surgery on the opposite eye within the post-operative period, however the physicians failed to use the appropriate modifiers.

Analysis of the April to October 1993 carrier data reflects a reduction in the overall denial rate of 51.5%. Only 46 of the total denials were for medical necessity. The classification for reporting these denials was correct during the 1993 study period.

GAO Claim Data: There is no GAO data.

Conclusion: A comparative analysis of the data reflects that educational efforts regarding global surgery policy have decreased the denial rate. The problems noted were errors in the classification of denials as medical necessity instead of global surgery and did not effect the outcome. The claims were denied correctly.

71020: Radiologic examination, chest, two views, frontal and lateral

Historical: Transamerica had no formal criteria for chest x-rays. Paper claims were reviewed as they were entered to identify "routine" examinations. EMC claims were reviewed if they suspended for any reason.

Community Notice: Information was published in the Medicare Billing Manual dated 1992; Special Medical Policy Issue dated June 1989, September 1990, September 1991; Focused Medical Review Study Findings dated September 27, 1993; Final Notice on Focused Medical Review Study Findings dated February 25, 1994.

Current: A focused study was conducted in 1993 as a result of aberrancies detected in services per 1000 beneficiaries. The diagnoses utilized in 33% of the claims were for routine examinations. Final criteria was implemented in March 1994, following the Notice and Comment process.

Analysis: The BESS data for 1993 (downloaded from HCFA) resulted in a focused study, as indicated above.

Analysis of the April to October 1992 carrier data reflects that medical necessity denials ranked fifth, and were 4.01% of total denials. The data for April to October 1993 reflects that medical necessity denials moved to third and increased to 8.4% of all denials. This comparison further supports the data which led to the focused review study.

GAO Claim Data: There is no GAO claim data.

Conclusion: There is a trend toward increased routine testing by physicians for asymptomatic patients. Follow-up of the newly established diagnostic criteria will be conducted in six months.

There also needs to be further clarification from HCFA as to what constitutes "screening." Review of other carriers' policies reflects wide variation in coverage, with some carriers routinely allowing for pre-operative testing of asymptomatic patients.

76091: Mammography; bilateral

Historical: Diagnosis criteria for diagnostic mammographies was developed as a result of physicians billing for screening tests prior to the time that screening was covered. Diagnostic mammograms are performed in the presence of a palpable mass or other symptomatology. They include a sharper focus on the area of suspected pathology and additional views. ' Screening mammograms are performed in the absence of personal symptomatology or disease. Modifications have been made over the years to the diagnosis criteria as medical practice evolved and diagnostic coding changed.

Community Notice: Articles were published on diagnostic mammography in the Special Medical Policy Issue dated September 1991, and in Your Medicare Newsletter issues #75, dated September 1993, and #77 dated March 1994.

Current: Additional diagnosis criteria were added in January, 1994 as a result of a Focused Medical Review Study. However, we still experience a large volume of medical necessity denials.

Analysis: The BESS data for 1993 (downloaded from HCFA) reflects that there is no aberrancy for allowed charges or services per 1000 beneficiaries. However, the overall denial rate for medical group, OB/GYN, and family practice specialties is higher than the national average.

Analysis of the April to October 1992 data reflects that medical necessity denials are the second highest reason for denial. The primary reason is lack of UPIN number. The analysis of April to October 1993 data reflects that medical necessity denials are the highest reason for denial, followed by duplicate denials.

GAO Claim Data: Analysis of 10 beneficiaries' claims showed all services were denied with the same medical necessity message (Diagnosis does not support the service).

Because the conditions reflected in the claims did not warrant a diagnostic mammography, the beneficiaries may have actually been receiving a screening mammography, which was submitted as a diagnostic mammography.

33% of the sample was for inpatient or outpatient interpretation services. This may indicate inadequate information from the ordering physician to the interpreting physician to determine the reason the study was ordered.

76091 continued:

Conclusion: It appears that many of the services billed as diagnostic mammography were actually screening mammography services (no evidence of personal symptomatology). Transamerica will continue its education process regarding the patient's rights to screening mammographies. We will also remind ordering physicians to clearly specify the symptoms or conditions justifying a diagnostic mammography when referring patients to the performing physicians.

HCFA needs to re-evaluate its screening mammography requirements. The lack of, or inaccessibility to, screening mammography centers may be depriving the beneficiary of covered services, simply because a non-screening center is performing the service.

Additionally, there are differences among carriers as to what constitutes a "diagnostic" test. Some carriers are including the "V" code identified by HCFA as an appropriate indication for screening mammographies as covered for diagnostic tests. Some further direction from HCFA is needed to develop national consistency.

88305: Level IV - Surgical pathology, gross and microscopic examination.

Historical: Prior to 1992, this procedure code was described as "Surgical pathology, gross and microscopic examination of presumptively abnormal tissue(s); single complicated specimen or specimen composed of multiple uncomplicated tissue, without complex dissection." Because of billing and coding problems, physicians were required to indicate on the billing the sites from which the specimens were collected. Multiple specimens billed on the same day that were not appropriately identified were denied with utilization reason codes.

Community Notice: An article was published in Your Medicare Newsletter issue #75 dated September 1993.

Current: In 1992, the descriptors for all surgical pathology codes changed to reflect that the unit for the code is the specimen. Prior to 1992, the term "specimen" was poorly defined, and included complex combinations of the number of pieces of tissue, number of slides prepared and the size of the tissue removed. In 1992, a specimen is defined as tissue or tissues that is (are) submitted for individual and separate attention, requiring individual examination and pathologic diagnosis. Two or more specimens from the same patient could each be appropriately assigned an individual code.

As a result of this change, and in cooperation with the medical community, extensive analysis was made of billing patterns and instructions. Claims from 34 high volume providers were analyzed and the pathology services compared with excisional services to verify their validity. On March 18, 1993, revisions were made to claims processing instructions to reduce the number of claims to be reviewed. It allowed the multiple services to be billed within the same claim.

Analysis: A Focused Review performed in 1993 reflected changes in billing patterns consistent with the new coding, but still some existing confusion on the proper level code to utilize. Education was performed via Your Medicare Newsletter.

Analysis of the April to October 1992 carrier data reflects that 5.1% of total denials were for medical necessity. Analysis of April to October 1993 carrier data reflects that 2.6% of total denials were for medical necessity.

GAO Claim Data: There is no GAO data.

Conclusion: Based on our continuing communications with the medical community, the 1992 revisions to the CPT descriptors and our educational efforts have lessened coding confusion. No current problems are evident.

92982: Percutaneous transluminal coronary balloon angioplasty; single vessel

Historical: When PTCA procedures were first developed, surgeries were performed on patients whose level of stenosis would have otherwise indicated no intervention be attempted. Criteria was developed with a minimum and maximum stenosis level (at which point CABG surgery would normally be performed).

Pre-payment medical necessity review was discontinued in early 1993 because we no longer saw services billed which were not medically indicated.

Prior to Physician Payment Reform (PPR), an assistant surgeon was allowed for this procedure. As of January 1, 1992, PPR placed a restriction on payment for an assistant on this procedure.

Community Notice: Articles were published in Your Medicare Newsletter issues # 61 dated September 1989, #63 dated May 1990, #65 dated December 1990, #69 dated February 1992, # 71 dated September 1992 and #73 dated March 1993. There was also a Policy Statement issued July 14, 1989.

Current: No pre-payment medical necessity review is performed on the surgeons' billing.

PPR sets a payment restriction for assistants at surgery unless supporting documentation is submitted to establish medical necessity. Payment may be made upon appeal, however assistants are rarely used for this procedure anymore.

Analysis: The BESS data for 1993 (downloaded from HCFA) reflects that there are no aberrancies, and that the overall denial rate is within national averages.

Analysis of the April to October 1992 carrier data reflected medical necessity denials to be the highest reason for denial. The data reflected that physicians had not yet stopped using assistants. Analysis of the April to October 1993 carrier data reflected 197 medical necessity denials, second to duplicate denials.

GAO Claim Data: Analysis of 20 beneficiaries' claims showed 18 were services for assistants-at-surgery denied for medical necessity (Diagnosis does not support the service), and the remaining two were surgeries denied with a medical necessity action code (Too many services within this period of time). There did not appear to be errors in processing.

92982 continued:

Conclusion: The high denial rate is a result of national policy changes included in Physician Payment Reform. With the elimination of prepayment medical necessity review, there are few medical necessity denials except for assistants at PTCA services. No current problems are evident.

93307: Echocardiography real-time with image documentation (2D) with or without M-Mode recording, complete

Historical: In 1990 we experienced fragmentation of diagnostic studies, as well as questionable medical necessity. Edits were developed in August 1990. In March 1991 we received the American College of Cardiology/American Heart Association Guidelines for the Clinical Application of Echocardiography. Diagnosis edits were modified based on the guidelines.

Community Notice: Articles were published on echocardiography in the Special Medical Policy Issue dated September 1990 and September 1991.

Current: In on-going communications with physicians, there has been no indication of dissatisfaction with the existing diagnostic criteria.

Analysis: The BESS data for 1993 (downloaded from HCFA) reflects that there is an aberrancy in allowed charges and services per 1000 beneficiaries for independent physiological laboratories. Other specialties performing this service are close to national averages.

The overall denial rate for all specialties is generally higher than the national average.

Analysis of the April to October 1992 carrier data reflects that medical necessity denials are ranked second to denials for lack of UPIN. Analysis of the April to October 1993 data reflects that medical necessity denials are first, followed by duplicate denials.

GAO Claim Data: Analysis of 10 beneficiaries claims showed all services were denied with the same medical necessity message (diagnosis does not support the service).

The data also reflected that out of 414 beneficiaries in the study, 131 (31.6%) of them accounted for 418 (59.1%) of the total 707 denials. There is a pattern of physicians billing for the same service multiple times without additional documentation, resulting in the same service being denied again for medical necessity. These "rebillings" ranged from two to nine rebillings for the same date of service. Many of the problems centered around one physician. Review of current billing patterns indicates he has corrected the rebilling problem.

There is a pattern by several physicians of multiple or a battery of diagnostic tests being performed on the same day, many of which are also denied for medical necessity.

93307 continued:

Conclusion: Transamerica is performing a focused review to address the aberrancies by the IPL's. This study will be complete by the end of September 1994. We will also evaluate the diagnosis criteria, by the end of September, to determine if current medical practice would affect the allowable conditions.

93320: Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; complete

Historical: In 1990 we experienced fragmentation of diagnostic studies, as well as questionable medical necessity. Edits were developed in August 1990. In March 1991 we received the American College of Cardiology/American Heart Association Guidelines for the Clinical Application of Echocardiography. Diagnosis edits were modified based on the guidelines.

Community Notice: Articles were published on echocardiography in the Special Medical Policy Issue dated September 1990 and September 1991; Your Medicare Newsletter issue #72 dated January 1993, #74 dated July 1993; and in a Special Policy Statement dated April 11, 1990.

Current: There has been little communication from the community regarding the diagnosis criteria established for this code.

Analysis: The BESS data for 1993 (downloaded from HCFA) reflects that there is a small aberrancy in services per 1000 beneficiaries for multispecialty groups and independent physiological laboratories. However, the volume is not significant to justify this code as one of the top 30 for focused review at this time.

The overall denial rate for all specialties is generally higher than national average. The highest rate of denial is for multispecialty medical groups.

Analysis of the April to October 1992 carrier data reflects that medical necessity denials are ranked second to denials for lack of UPIN. Analysis of the April to October 1993 data reflects that medical necessity denials are first, followed by duplicate denials.

GAO Claim Data: Analysis of 10 beneficiaries claims showed all services were denied with medical necessity messages (diagnosis does not support the service; more than one service per day; too many services in this period of time).

There is a small pattern of physicians billing for the same service multiple times without additional documentation, resulting in the same service being denied again for medical necessity. There is a pattern by several physicians of multiple or a battery of diagnostic tests being performed on the same day, many of which are also denied for medical necessity.

Six of the beneficiaries had claims for inpatient or outpatient interpretations. This may indicate that there is a lack of communication from the ordering physician as to the indications or symptoms for which the test was ordered.

93320 continued:

Conclusion: Transamerica will continue to advise physicians ordering tests of the need to provide enough information on their orders to enable interpreting physicians to bill properly. This will be accomplished through future newsletter articles.

We will also evaluate the diagnosis criteria to determine if current medical practice would affect the allowable conditions. This will be performed before the end of September.

99231: Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; medical decision making that is straightforward or of low complexity.

Historical: Evaluation and Management (E&M) codes became effective with dates of service January 1, 1992 and after. Per HCFA instructions, the only medical necessity edits which were to be utilized were for concurrent care.

Additional "bundling" type edits were installed at various times throughout 1992.

Community Notice: Articles were published on E&M codes in Your Medicare Newsletter issues #69 dated February 1992, #70, dated June 1992, #71 dated September 1992, #72 dated January 1993, #73 dated March 1993, #74 dated July 1993, #76 dated January 1994, and #77 dated March 1994; and in Medicare Billing Manual, 1992.

Current: There have been no recent changes in instructions from HCFA, and no focused studies have yet been performed on E&M codes. We continue to provide education in our post-payment activities with physicians.

Analysis: E&M codes are not included in the downloaded data from HCFA. Analysis of the April to October 1992 carrier data reflects that 68.8% of the medical necessity denials reported for this period were incorrect. The message used (this service included in the pre- or post-op care) was correctly related to the physicians and beneficiaries, but incorrectly classified for reporting as a medical necessity denial. It should have been classified as an "other" denial, based on the global surgery policy. This incorrect classification did not affect the outcome of the claims. This denial code did not appear in the sampling from the GAO data.

For April to October 1993, 42% of the medical necessity denials were classified incorrectly. The messages used for HCFA's bundled visit edits were incorrectly reported, as discovered in the GAO data. The incorrect classifications began during single copy load of new messages in October 1992.

GAO Claim Data: Analysis of 10 beneficiaries' claims showed that five (5) beneficiaries were denied a total of thirty-one services with the correct non-medical necessity messages (Medicare does not pay separately for this service, or Medicare will only pay for one hospital visit or consult per physician per day). However, the denial was classified incorrectly for reporting. These are coding denials, based on HCFA's coding instructions for E&M codes. The remaining beneficiaries' services were denied correctly as medical necessity for concurrent care (similar services by similar specialties; multiple physicians).

99231 continued:

Conclusion: The messages for denials transmitted to physicians and beneficiaries were correct. The classification for reporting was incorrect, but did not affect the outcome of the claims. Transamerica will update the classifications as needed.

99332: Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of moderate complexity.

Historical: Evaluation and Management (E&M) codes became effective with dates of service January 1, 1992 and after. Per HCFA instructions, the only medical necessity edits which were to be utilized were for concurrent care.

Additional "bundling" type edits were installed at various times throughout 1992.

Community Notice: Articles were published on E&M codes in Your Medicare Newsletter issues #69 dated February 1992, #70, dated June 1992, #71 dated September 1992, #72 dated January 1993, #73 dated March 1993, #74 dated July 1993, #76 dated January 1994, and #77 dated March 1994; and in Medicare Billing Manual, 1992.

Current: There have been no recent changes in instructions from HCFA, and no focused studies have yet been performed on E&M codes. We continue to provide education in our post-payment activities with physicians.

Analysis: E&M codes are not included in the downloaded data from HCFA. No data was downloaded from our system, as this code was not on the list of codes studied by GAO. However, the Regional Office did request GAO data on it.

GAO Claim Data: The GAO data contained a total of six (6) claims for this code. Analysis showed that two (2) beneficiaries were denied services with the correct non-medical necessity messages (Medicare does not pay separately for this service, or Medicare will only pay for one hospital visit or consult per physician per day). However, the denial was classified for reporting incorrectly. This incorrect classification did not affect the outcome of the claims. These are coding denials, based on HCFA's coding instructions for E&M codes. The remaining beneficiaries' services were denied correctly as medical necessity for concurrent care (similar services by similar specialties; multiple physicians).

Conclusion: The messages for denials transmitted to physicians and beneficiaries were correct. The classification for reporting was incorrect, but did not affect the outcome of the claims. Transamerica will update the classifications as needed.

99233: Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of high complexity.

Historical: Evaluation and Management (E&M) codes became effective with dates of service January 1, 1992 and after. Per HCFA instructions, the only medical necessity edits which were to be utilized were for concurrent care.

Additional "bundling" type edits were installed at various times throughout 1992.

Community Notice: Articles were published on E&M codes in Your Medicare Newsletter issues #69 dated February 1992, #70, dated June 1992, #71 dated September 1992, #72 dated January 1993, #73 dated March 1993, #74 dated July 1993, #76 dated January 1994, and #77 dated March 1994; and in Medicare Billing Manual, 1992.

Current: There have been no recent changes in instructions from HCFA, and no focused studies have yet been performed on E&M codes. We continue to provide advice on correct billing and coding in our post-payment activities with physicians.

Analysis: E&M codes are not included in the downloaded data from HCFA. Analysis of the April to October 1992 carrier data reflects that 74.9% of the medical necessity denials reported for this period were incorrect. The message used (this service included in the pre- or post-op care) was correctly related to the physicians and beneficiaries, but incorrectly classified for reporting as a medical necessity denial. It should have been classified as an "other" denial, based on the global surgery policy. This incorrect classification did not affect the outcome of the claims. This denial code did not appear in the sampling from the GAO data.

For April to October 1993, 20% of the medical necessity denials were classified incorrectly. The incorrect classification began during single copy load of new messages in October 1992.

GAO Claim Data: Analysis of 10 beneficiaries' claims showed that 29 services for seven (7) beneficiaries were all denied with the correct non-medical necessity messages (Medicare does not pay separately for this service, or Medicare will only pay for one hospital visit or consult per physician per day). However, the denial was classified incorrectly for reporting to CWF. These are coding denials, based on HCFA's coding instructions for E&M codes. Three (3) services for two beneficiaries were denied with medical necessity denials for multiple services the same day, but should have been denied as "included" rather than for frequency, based on HCFA's coding instructions. One service was denied correctly as medical necessity for concurrent care (similar services by similar specialties).

99233 continued:

Conclusion: The messages for denials transmitted to the physicians and beneficiaries were correct. The classification for reporting was incorrect but did not affect the outcome of the claims. Transamerica will update the classifications as needed.

99238: Hospital discharge day management

Historical: Evaluation and Management (E&M) codes became effective with dates of service January 1, 1992 and after. Per HCFA instructions, the only medical necessity edits which were to be utilized were for concurrent care.

Additional "bundling" type edits were installed at various times throughout 1992.

Community Notice: Articles were published on E&M codes in Your Medicare Newsletter issues #69 dated February 1992, #70, dated June 1992, #71 dated September 1992, #72 dated January 1993, #73 dated March 1993, #74 dated July 1993, #76 dated January 1994, and #77 dated March 1994; and in Medicare Billing Manual, 1992.

Current: There have been no recent changes in instructions from HCFA, and no focused studies have yet been performed on E&M codes. We continue to provide education in our post-payment activities with physicians.

Analysis: E&M codes are not included in the downloaded data from HCFA. Analysis of the April to October 1992 carrier data reflects that 50.3% of the medical necessity denials reported for this period were incorrect. The message used (this service included in the pre- or post-op care) was correctly related to the physicians and beneficiaries, but incorrectly classified for reporting as a medical necessity denial. It should have been classified as an "other" denial, based on the global surgery policy. This incorrect classification did not affect the outcome of the claims.This denial code did not appear in the sampling from the GAO data.

For April to October 1993, 81% of the medical necessity denials were classified for reporting incorrectly. The messages used for HCFA's bundled visit edits were incorrectly reported, as discovered in the GAO data. The incorrect reporting began during single copy load of new messages in October 1992.

GAO Claim Data: Analysis of 10 beneficiaries' claims showed that six (6) beneficiaries were denied services with the correct non-medical necessity messages (Medicare does not pay separately for this service, or Medicare will only pay for one hospital visit or consult per physician per day). However, the denial was classified for reporting incorrectly. These are coding denials, based on HCFA's coding instructions for E&M codes. The remaining beneficiaries' services were denied correctly as medical necessity for concurrent care (similar services by similar specialties; multiple physicians).

99238 continued:

Conclusion: The messages for denials transmitted to physicians and beneficiaries were correct. The classification for reporting was incorrect, but did not affect the outcome of the claims. Transamerica will update the classifications as needed.

Additional advice will be provided to the community by newsletters and in seminars regarding the appropriate reporting of discharge day services by someone other than the attending physician.

99283: Emergency department visit for the evaluation and management of a patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of moderate complexity.

Historical: Evaluation and Management (E&M) codes became effective with dates of service January 1, 1992 and after. Per HCFA instructions, the only medical necessity edits which were to be utilized were for concurrent care.

Additional "bundling" type edits were installed at various times throughout 1992.

Community Notice: Articles were published on E&M codes in Your Medicare Newsletter issues #69 dated February 1992, #70, dated June 1992, #71 dated September 1992, #72 dated January 1993, #73 dated March 1993, #74 dated July 1993, #76 dated January 1994, and #77 dated March 1994; and in Medicare Billing Manual, 1992.

Current: There have been no recent changes in instructions from HCFA, and no focused studies have yet been performed on E&M codes. We continue to provide education in our post-payment activities with physicians.

Analysis: E&M codes are not included in the downloaded data from HCFA. Analysis of the April to October 1992 carrier data reflects that 10.2% of the medical necessity denials reported for this period were incorrect. The message used (this service included in the pre- or post-op care) was correctly related to the physicians and beneficiaries, but incorrectly classified for reporting as a medical necessity denial. It should have been classified as an "other" denial, based on the global surgery policy. This denial code did not appear in the sampling from the GAO data.

For April to October 1993, 96.2% of the medical necessity denials were classified for reporting incorrectly. The messages used for HCFA's bundled visit edits were incorrectly reported, as discovered in the GAO data. The incorrect reporting began during single copy load of new messages in October 1992.

GAO Claim Data: Analysis of 10 beneficiaries' claims showed that six (6) beneficiaries were denied services with the correct non-medical necessity messages (Medicare does not pay separately for this service, or Medicare will only pay for one hospital visit or consult per physician per day). However, the denial was classified incorrectly for reporting. These are coding denials, based on HCFA's coding instructions for E&M codes. The remaining beneficiaries' services were denied correctly as medical necessity for multiple providers performing similar services the same day (similar services by similar specialties; multiple physicians).

99283 continued:

Conclusion: The messages for denials transmitted to physicians and beneficiaries were correct. The classification for reporting was incorrect, but did not affect the outcome of the claims. Transamerica will update the classifications as needed.

93880: Duplex scan of extracranial arteries; complete bilateral study

Historical: This code is within a range of services known as Non-Invasive Vascular Diagnostic Studies. As a result of significant abuse over the years, going back prior to 1986, we have performed extensive studies and worked with the community to establish stringent medical necessity criteria to prevent abuse.

Community Notice: Articles were published on non-invasive studies in the Special Medical Policy Issue dated June 1989, September 1990, and September 1991, in a special Policy Statement mailing dated April 1990, and in Your Medicare Newsletter issue #63 dated September 1991, and #68 dated June 1992.

Current: Due to identified abuse of these services, we used an Ad Hoc committee of vascular physicians, Independent Physiology Laboratories and vascular technologists when developing our medical necessity criteria. This diagnosis criteria is in place, and there has been little further communication from the medical community regarding the diagnosis criteria established for this code.

Analysis: The BESS data for 1993 (downloaded from HCFA) reflects that there is no significant aberrancy in allowed charges or services per 1000 beneficiaries. The overall denial rate is in line with national averages.

Analysis of the April to October 1992 and the same period in 1993 reflects medical necessity denials as the number one reason for denials.

GAO Claim Data: Analysis of 10 beneficiaries claims showed all services were denied with medical necessity messages (diagnosis does not support the service; information does not support this many services).

There is some evidence of rebilling the same service resulting in additional medical necessity denials for the same service, but the volume is small.

Conclusion: No current problems are evident, although an evaluation of the diagnosis criteria based on any changes in medical practice will be made by the end of September.

99222: Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity.

Historical: Evaluation and Management (E&M) codes became effective with dates of service January 1, 1992 and after. Per HCFA instructions, the only medical necessity edits which were to be utilized were for concurrent care.

Additional "bundling" type edits were installed at various times throughout 1992.

Community Notice: Articles were published on (Evaluation and Management) E&M codes in Your Medicare Newsletter issues #69 dated February 1992, #70, dated June 1992, #71 dated September 1992, #72 dated January 1993, #73 dated March 1993, #74 dated July 1993, #76 dated January 1994, and #77 dated March 1994; and in Medicare Billing Manual, 1992.

Current: There have been no recent changes in instructions from HCFA, and no focused studies have yet been performed on E&M codes. We continue to provide education in our post-payment activities with physicians.

Analysis: E&M codes are not included in the downloaded data from HCFA. Analysis of the April to October 1992 carrier data reflects that 56.9% of the medical necessity denials reported for this period were incorrect. The message used (this service included in the pre-or post-op care) was correctly related to the physicians and beneficiaries, but incorrectly classified for reporting as a medical necessity denial. It should have been classified as an "other" denial, based on the global surgery policy. This denial code did not appear in the sampling from the GAO data.

For April to October 1993, 42.2% of the medical necessity denials were classified for reporting incorrectly. The messages used for HCFA's bundled visit edits were incorrectly reported, as discovered in the GAO data. The incorrect reporting began during single copy load of new messages in October 1992.

GAO Claim Data: Analysis of 10 beneficiaries' claims showed that two (2) beneficiaries were denied with the correct non-medical necessity messages (Medicare does not pay separately for this service, or Medicare will only pay for one hospital visit or consult per physician per day). However, the denial was classified incorrectly for reporting. These are coding denials, based on HCFA's coding instructions for E&M codes. Three (3) beneficiaries services were denied with medical necessity denials for multiple services the same day, but should probably have been denied as duplicates (multiple

99222 continued:

billings by the same physician). Four (4) beneficiaries' services were denied correctly as medical necessity for concurrent care (Similar services by similar specialties).

Conclusion: The messages for denials transmitted to physicians and beneficiaries were correct. The classification for reporting was incorrect, but did not affect the outcome of the claims. Transamerica will update the classifications as needed. Additional training is being conducted on duplicate claim processing to ensure consistency of claims handling.

PATIENT ADVOCATE COMMITTEE
238 East Main Street
Gas City, Indiana 46933
(317) 674-7708

Jan 13, 1995

Congressman Ron Wyden
1111 Longworth Office Bldg.
Washington, D.C., 20515

Dear Congressman Wyden,

Following the Christmas week televised hearing of your Small Business Committee's inquiry into Medicare reimbursements I spoke with your aide, Josh Karden. After I explained a little about our Patient Advocate Committee in Marion and our State Medicare Oversight Coalition, which meets every two months in Indianapolis, he asked me to put this into a letter along with any recommendations our Committee might have as to how to solve some of the Medicare reimbursement problems. He stated he would include our remarks with the transcript of that meeting. That information appears on the following pages.

Sincerely,

Marion Thompson

(Miss) Marion Thompson
Senior Citizen Representative
520 W. Nelson St. Apt. 208
Marion, In. 46952
(317) 668-8180

P.S. Thank you for the transcript of the hearing of your committee about Medicare reimbursements.

MEDICARE
and
HEALTH
INSURANCE
PROBLEMS

PATIENT ADVOCATE COMMITTEE
238 East Main Street
Gas City, Indiana 46933
(317) 674-7708

January 13, 1995

Congressman Ron Wyden
1111 Longworth Office Bldg.
Washington, D.C., 20515

PATIENT ADVOCATE COMMITTEE RECOMMENDATION FOR EXPEDITING SOLVING OF MEDICARE BILLING AND REIMBURSEMENT PROBLEMS: HELP ESTABLISH IN OTHER STATES A MECHANISM SIMILAR TO (IMOC) INDIANA MEDICARE OVERSIGHT COALITION.

Our Patient Advocate Committee (PAC) started in 1985 and our Indiana State Medicare Oversight Coalition (IMOC) started in 1988. A brochure touching on the issues the original members identified and started documenting in '85 and an Insurers Performance Review Committee (IPRC) Bulletin describing the hearing held by a State Summer Study Committee in '88 are included.

While the issues described in the PAC Bulletin do keep recurring, we now have the cooperation of the Carrier in addressing them. When the Carrier learns now that they are the source of a problem they even ask for the identity of the person(s) causing the problems(s) so they can go back and do the necessary training.

In addition, when HCFA, Baltimore, sends new policies to the Carrier for review and comment, it has become routine for the Carrier to bring them to the Coalition meetings and ask for the members input also.

Twice PAC has referred to the Gray Panthers attorneys. Once was in '88 when our Carrier removed the codings from the front of the EOMBs. This issue was part of HCFA's testimony at the State House when we had our hearing. They claimed, improperly, that it was because of the Gray Panther's suit that the codings had been removed. With this letter, that statement was refuted.

The second time was in '92 when the Carrier was threatening to disconnect the patient's "800" number. Armed with that letter, we were able to end that threat. Copies of both letters from the Gray Panthers attorneys are included.

This Coalition was always meant to work for everyone. In '92, when the RVRBS came in, the Regional Office of HCFA in Chicago gave our Carrier wrong instructions as to how providers should bill for Medicare Secondary Payer (MSP). We did not learn of this error until '93.

PAC contacted HCFA, Baltimore, for an explanation of how this could have happened and why it was not corrected sooner. Baltimore was not anxious to respond but, finally, with the help

BEST COPY AVAILABLE

of Senator Lugar's Washington office (to get a response, they ended up sending everything over to Mr. Vladek), we did get a partial response from Carol Walton. The final response did not arrive for several months after that (and another letter from Senator Lugar's office to Mr. Vladek). The answer: Chicago did give the Carrier wrong instructions. Some documentation of this is also included.

We now have met the goal that the Coalition does work for everyone. 1) The Carrier has been cleared of responsibility for giving out the wrong instructions and the Providers from knowingly breaking Federal law. 2) With the codings, both providers and patients have been helped because it is only through the codings that the provider offices can tell whether or not a claim has been paid properly or where an error is. 3) With the "800" number, we clearly have saved a vital service for the patients.

Also included is a copy of our resolution to the White House Conference on Aging which would set up Coalitions like ours in the rest of the 50 states. We believe all states should have the same opportunity to address their problems that we enjoy in Indiana. If we can furnish any other information, feel free to call or write us.

Sincerely,

Marion Thompson

(Miss) Marion Thompson
520 W. Nelson St. Apt. 208
Marion, In. 46952
(317) 668-8180

Chronicle-Tribune, Marion, Indiana Tuesday, Feb. 24, 1987

Woman takes on Medicare patient payment system

By WILLIAM JACKSON
C-T Staff Writer

A 59-year-old Marion woman is challenging the way Medicare payments to patients are figured.

• • •

She said she does not expect Medicare to approve 100 percent of the bill — "It's not set up to pay the whole thing." But she thinks her doctor's charge was reasonable and would like to see a reasonable percentage of it paid.

"I happen to feel he's the best doctor I could find," she said. "I feel he's entitled to every penny he asked for. And he'll get it, eventually. I just feel that Medicare should have helped out a little more."

Although Thompson said she thought she had an obligation to challenge what she thought was an unfair decision, her action is more than a matter of principle. Medicare's decision left her responsible for an unpaid balance of $419.40 for the operation, and she has a monthly income of $426 in Social Security payments.

Thompson said too often people do not challenge decisions made by officials.

"I think too many people are afraid to pursue it," she said. "I think sometimes you have to gird yourself and say, 'Look, I have this right as an American, and I am going to avail myself of this right.' So that if this process doesn't work for me, at least I'll know why it doesn't work."

C-T Photo by Alan Petersime

Marion Thompson says she is just trying to right a wrong.

DO YOU HAVE PROBLEMS GETTING YOUR REIMBURSEMENT FROM THE MEDICARE CARRIER?

DO YOU TAKE CARE OF SOMEONE WHO DOES?

Members of the Patient Advocate Committee often hear questions and comments such as the following:

"Am I the only one who did not get reimbursed?"
"Why is the payment so low?"
"Why does it take so long to receive my Medicare payment?"

YOU ARE NOT ALONE WITH THESE PROBLEMS. THERE IS HELP.

CALL
THE PATIENT ADVOCATE COMMITTEE

OR
YOUR DOCTOR

BEST COPY AVAILABLE

Why Is Your Reimbursement So Low?

You may have been led to believe that your reimbursement is so much lower than what your doctor charged because your doctor charged too much. However, a recent investigation by the Patient Advocate Committee discovered that many of the Medicare reimbursements patients receive are not paid according to what your doctor charged. They are paid on a fee scale from charges for 1971, times an index set by the government each year (see excerpts of articles). We are sure this comes as a complete surprise to you, because it was to many members of the committee.

Underpayment can also be due to the many clerical and code transfer mistakes committed by the carrier. The Chronicle Tribune published a series of articles about this problem April 23-25, 1986. Your doctor's office could check whether this applies to your current reimbursement, but you have to bring or mail the EOMB (Explanation of Medicare Benefits) form to your doctor. The carrier does not send a copy of your EOMB form to your doctor. Therefore your doctor will not know that you were not reimbursed in a timely fashion.

Types of Denied, Delayed or Underreimbursed Medicare Claims

1) Denial of reimbursement for ambulance services although patients had met carriers own guidelines. For example, patients who were comatose or were on life support system during their trip in an ambulance have been denied reimbursement.

2) Improper rejections. The claims were paid when resubmitted through a congressman's office

3) Carrier holding Medicare checks longer than the 25 days allowed by the Health Care Financing Administration (Please compare date on reimbursement check with date of postmark on envelope.)

4) Carrier incorrectly stating that patient is deceased

5) Carrier requesting "additional" or "missing" information even though it is properly identified on the original claim

6) Non-assigned claims being paid to physicians as assigned and assigned claims being paid to the patient as non-assigned

7) Codes changed by carrier resulting in incorrect payments

8) Incorrect interpretation of the TEFRA ACT and alleging that a service could have been done in a doctor's office

9) "Bundling of codes" (Combining billing for multiple services under multiple codes into 1 code at the carrier's option then reimbursing for that code only).

10) "Lost" claims. On a number of occasions the carrier has contended it never received the claim from patient or billing office. This allegation has even been used regarding claims given to carrier's representatives at a meeting arranged in Marion at request of a member of congress. It will be even more important to keep a copy of your claim form and know the date it was sent when the carrier has to pay interest on clean claims delayed more than 30 days. Congress defined clean claims to be those which require no additional information to be processed

This law goes into effect April 1, 1987.

Chronicle-Tribune, Marion, Indiana Wednesday, Feb. 25, 1987

Medicare explanations called confusing

Explanations of how Medicare decides how much to reimburse patients are confusing and incomplete, a Medicare hearing officer said Tuesday.

The issue of how Medicare uses words such as "reasonable" and "prevailing" was raised Tuesday in a hearing on the reimbursement allowed for a Marion woman for surgery she received last July.

* * *

But Deloris Wilkes, hearing officer appointed by Blue Cross-Blue Shield of Indiana, which administers Medicare in Indiana, said the rate was not necessarily reasonable nor was the charge it was based on the prevailing charge in Indiana.

Those terms were coined by Medicare in the early '70s, Wilkes said. As the amount paid by Medicare for some medical services has fallen below what doctors actually charge, they are no longer descriptive of the policies.

Joy Newby, a medical billing agent representing Thompson in the hearing, called the explanations misleading and said they contribute to the feeling of many patients that they are being overcharged by their physicians.

According to the explanation of benefits given by Medicare to Thompson, the money she received should have been sufficient to pay the bills of three out of four doctors in this area performing the operation she received.

"This payment left me with more than half of the bill to pay myself," Thompson said. "I just don't see that the explanation explains the payment."

"I have to agree with you there," Wilkes said. "This would not explain to me how they arrived at any payment whatsoever. But the explanation of benefits meets the government's requirements."

As Wilkes explained it, Medicare's prevailing rates are based on what doctors actually charged in 1971. That amount is then multiplied by an economic modifier that is supposed to reflect changes in the overall economy.

However, the modifier does not correspond to actual increases in the cost of medical service and the final figure does not reflect what doctors actually charge today, Wilkes said.

Chronicle-Tribune, Marion, Indiana Saturday, November 1, 1986

Medicare providers told to speed up payments

By WILLIAM JACKSON
C-T Staff Writer

The federal government has told providers of Medicare benefits to speed up claims payments, but the chairman of Marion General Hospital's Patient Advocate Committee is not convinced there has been any improvement.

"I don't think there has been any definitive change," said Dr. John D. Pattison. "The law has been changed, but they can play around with that."

The Patient Advocate Committee was established in Marion in July to investigate and monitor the performance of Blue Cross, Blue Shield of Indiana, which administers Medicare in Indiana.

Charles Miller, spokesman for Blue Cross, said there was a slowdown in claims processing when new Medicare regulations went into effect last summer. This resulted in what officials for the Health Care Financing Administration called "an unacceptable performance level."

In September, HCFA established a new policy calling for at least 95 percent of all properly-filed Medicare claims to be paid within 27 days. To meet this goal, the agency released an additional $15 million to the 91 companies that have contracted to process Medicare claims across the country.

"We expect this standard to be fully met no later than Sept. 30, 1986," HCFA told all contractors.

According to HCFA, at one time during the summer, Indiana had a backlog of 450,000 unpaid Medicare claims, 150,000 of which were more than 30 days old.

In a newsletter prepared in September for the Indiana Congressional Delegation in response to complaints about poor service, Blue Cross claimed it already had reduced its backlog of unpaid claims.

The number of claims unpaid after 30 days dropped from 134,671 on April 1, to 106,501 on July 1, and to less than 25,000 as of Sept. 26.

New requirements for speedy payment refer only to what are known as "clean claims" — claims that do not have to be sent back to the doctor or patient for more information.

But one of the complaints of the Patient Advocate Committee is that too many properly-filed claims are being returned by the insurance company unnecessarily, asking for unneeded information. Although these claims are paid when refiled by the doctor, this delays payment by at least 45 days, Pattison said.

Because of complaints from the Patient Advocate Committee, HCFA has ordered an investigation into unnecessary delays in Indiana and instructed the management of the insurance company to take whatever action is necessary to ensure that the delays do not continue.

Pattison said Grant County patients are being notified that Medicare claims should be paid within 27 days. He said any patient with a Medicare claim that is delayed should report that fact to his physician.

BEST COPY AVAILABLE

Insurer Performance Review

Marion, Indiana OCTOBER, 1988
Published by the Insurer Performance Review Committee* of Grant County Medical Society. A. Shah, M.D., President. Opinions expressed are the views of the authors and not necessarily of the Society.

INDIANA MEDICARE OVERSIGHT COALITION - FIRST IN THE NATION

(dp, tu) A coalition of senior citizen organizations, physicians and other patient advocates, has begun meeting on a monthly basis in Indianapolis at the Indiana State Medical Association Headquarters with Medicare carrier representatives. This prototype coalition is one of a kind in the entire nation. During its first meetings, in September and October of this year, it dealt with multiple problems pertaining to MAAC's, medical necessity and misreimbursement by the carrier. The Medicare carrier initiated many remedial measures, including doubling of staff in some sections, retraining of personnel and modification of its computer software.

The road to the coalition mechanism was long with some unexpected twists. Two Grant County based committees, the Patient Advocate Committee (PAC) and the Insurer Performance Review Committee (IPRC) of the Grant County Medical Society, had been documenting Medicare reimbursement problems for several years. State Representatives T. Boatwright and P. Beck became convinced of a need for remedial action, and in January, 1988 introduced HCR-6. It asked the Indiana Legislative Council to "direct a health or insurance-related interim study committee to examine the feasibility of creating an oversight commission to watch over health insurance companies that are also administrators of Medicare and Medicaid." Since Grant County Medical Society is a small one, the committees counted on substantial aid from others, since they knew the carrier had a number of experienced lobbyists at the State House.

Some professional medical lobbyists considered the issue too hopeless to bother with, since the issues were complex and little known by legislators. However, they did not anticipate the grass roots feelings of both patients and physicians throughout the state. The Patient Advocacy Committee, which consists of physicians, senior citizens and billing agents, grew in strength and added members from other counties. The patient advocates informed the newly acquired supporters about the Beck and Boatwright resolution. IPRC also contacted all 15 members of the Legislative Council and informed them that many letters-to-the-editor were appearing about this issue. IPRC asked all county medical society presidents for help to contact the legislators in their region. In addition, IPRC established a "Mishandled Clean Claim of the Month" series and forwarded these examples to the legislators. When decision time arrived, the Legislative Council, both the Republicans and Democrats, voted

(Continued on page 2)

CONGRESSIONAL AND SOCIAL SECURITY OFFICES RECEIVE MANY CONSTITUENT REQUESTS FOR HELP WITH MEDICARE REIMBURSEMENT PROBLEMS

(dp) Grazina Paegle, a member of the Patient Advocate Committee, and F. Handlon, President of United Senior Action for Central Indiana and Field Representative for Congressman Andy Jacobs, surveyed nearly all of the Congressional offices in Indiana regarding the volume of Medicare claims brought to them by constituents. All of the offices had a substantial number of constituent requests for help. None of the offices had personnel specifically trained in Medicare coding and billing methods. The majority of them expressed interest in having a clearing-house function, which could be provided by an oversight coalition, commission or another mechanism.

The volume of claims handled by each Congressional district is estimated as between 1,200 to 1,500 per year. The initial estimate was provided to us by former Congressman Bud Hillis's staff aide, Mrs. C. Grimsley. It was confirmed with Congressman Jontz's staff members from Valparaiso. Although the volume may vary somewhat from office to office and district to district, the volume of requests for help has remained high. Therefore, it can be estimated that the offices of the Indiana delegation to the U.S. Congress receive approximately 15,000 claims a year from their constituents. Since Congressional staffers are not trained in Medicare billing and coding intricacies, they have a problem. They are in no position to evaluate whether a respective constituent has been affected by a carrier or

(continued on page 3)

NETWORKING AND SEMINARS

•(gp) Dr. John Pattison and Grazina Paegle were guest speakers at the AMA Medical Services Council Meeting during the AMA Spring Meeting in Chicago. They presented the work of PAC (Patient Advocate Committee) and recommended to the participants that "networking," sharing information about Medicare problems, across state lines would benefit everyone. The idea was very well received by the participants. The AMA Medical Services Council is presently working on a nationwide survey of physicians about specific problems of this type.

•The Patient Advocate Committee was asked by Iowa physicians to help them obtain their Level I, Level II, and Medicare Economic Index Reports from their

(continued on page 3)

---

*Members of the Committee: M.W. Donaldson, M.D.; L. Edwards; E.G. Guidera, M.D.; R.J. Jackson, M.D. (chairman); P.N. Joshi, M.D.; J. Kennedy; K.V. Murthy, M.D.; L.K. Musselman, M.D.; R.D. Paegle, M.D.; J.D. Pattison, M.D.; A. Shah, M.D.; T. Urgena, R.N.

Additional copies can be obtained from R. J. Jackson, M.D., 1009 Professional Arts Building, 500 Wabash Avenue, Marion, IN 46952.

BEST COPY AVAILABLE

unanimously to study this issue.

The Legislative Council referred the topic to the Interim Study Committee on Health Issues. Its chairman, D. Pool, tackled the complex problems systematically and did considerable prehearing gathering of information. It included meetings with interested parties. At one of the meetings, attended by representatives of Indiana AARP, United Senior Action, PAC, IPRC and the former president of the Allen County Medical Society, Representative Pool asked that additional data be obtained prior to the hearings. On the day of the hearings, the room was packed, mainly by patients and providers in favor of the resolution. The chairman did not even have enough time to let all of those in favor testify. Yet their presence was noted and their written depositions accepted.

Approximately three weeks before the scheduled hearings IPRC asked ISMA Board of Trustees for additional help with this issue. The President, President-elect and Chairman of the Board of Trustees of ISMA initiated a meeting on short notice in Grant County. During this meeting, Grant County physicians debated the commission concept and also proposed a more comprehensive coalition concept. They voted unanimously to endorse the coalition concept. They also asked their ISMA guests to: a) bring this resolution up at the following day's meeting of the ISMA Executive Committee and b) use the resources of the ISMA Legislative and Public Relation staffs to help and issue an appropriate press release. ISMA Executive Committee also approved the coalition concept.

The hearings occurred two days later. Since representatives Beck and Boatwright had initially asked for a comprehensive review of the issues and had used the commission idea as just a vehicle to get the debate started, they had no difficulty in endorsing the coalition mechanism at the hearings. They deserve much credit for starting the ball rolling and thinking of their constituents, our patients.

Poignant testimony by patients illustrated the hardships created by bureaucratic mistakes, including improper denials under the "medically unnecessary" label. The scale of the economic problems was also illustrated. An IPRC member had been told by a Blue Cross/Blue Shield of Indiana Vice-president, that Medicare handles 7,500,000 Medicare Part B claims in Indiana per year, worth approximately $330,000,000 to the more than 700,000 elderly beneficiaries. In a letter to IPRC, Dr. Otis Bowen, the Secretary of the Department of Health and Human Services, indicated that the Medicare carrier claims processing error rate is approximately 1%. That may be true in other areas of the United States, but evidence presented to the Health Subcommittee in Indiana indicated that the claims processing error rates in some regions in Indiana have been much higher, in some specialties as high as 30%.

This means that delays, underpayments or nonpayments may affect reimbursements totalling up to $100 million per year. That is a significant sum which the state of Indiana may ill afford to lose or have delayed.

Prompt reimbursement is even more important for individual patients. Some may delay treatment, if they cannot pay old bills. Some may lose their lives because of such delays. Physician members of the two committees know of cancer patients who have delayed seeking medical care because of previous misreimbursements by the Medicare carrier.

In addition, it may be well to know whether Indiana gets back the same amount of premium dollars as other states. There may be a discrepancy due to the type of code transfers, and carrier miscalculations of reimbursement since 1971, which were described at the hearings. No one at the hearings indicated that this had been checked out, as yet.

The tone of the hearings began to change from adversarial to a search for a cooperative solution after one of the Grant County physicians testified that the goal is not to replace the carrier, but to improve the system. It was noted that about 700 people are employed in Indiana by the Medicare and Medicaid sections of the carrier. The physician also noted that an in-state carrier is easier to contact when problems arise than would be the case if it were replaced by an out-of-state carrier.

Representative D. Pool deserves much credit for expediting the Indiana Oversight Coalition. During the hearings he persuaded the interested parties to try the coalition mechanism rather than wait for the establishment of a more formal, and probably more cumbersome oversight commission. Since the latter would have required state funding while the coalition is a non-governmental group, Representative Pool helped the state save money by favoring the coalition rather than the commission mechanism.

IMOC has its work cut out, since it has to contend with federal and state jurisdictions and consider the interests of the diverse participants, including patients, physicians, Medicare carrier, HCFA and Indiana legislators. It has gotten off to a good start. However, it does not have permanent staff. Therefore it could not handle a large number of patient claims nor help ease the burden of congressional offices, which also receive many requests for help with Medicare claims (See companion article). This will have to be considered soon. One solution could be to add a clearing-house function to the present Oversight Coalition (See article on page 4). In the meantime, the Oversight Coalition is successfully coping with significant Medicare reimbursement problems.

BEST COPY AVAILABLE

NETWORKING (Continued)

carrier. Blue Cross of Iowa reportedly wanted to charge physicians several thousand dollars for this data. PAC sought help from influential congressional staffs from Iowa, who, in turn, promised to intercede for the Iowa physicians.

•C. Stroyny, the current director of NCFA Region V, and his staff came to Grant County on May 20, 1988 to meet with the Patient Advocate Committee and review on site the Medicare carrier related problems. A follow-up meeting was agreed upon. This is a marked improvement from the preceding years when the previous director refused to visit grass roots and watched the statewide blacklog of claims grow to 450,000.

•IPRC held two seminars for phyisicians (June 23 and July 13, 1988). The physicians outside of Marion, who attended the seminars, entitled "Patient Advocacy and Insurer Performance Review," were surprised to learn how they have been set up as the "bad guys" by both the government and Medicare carrier, and how the misuse of terminology has damaged the physican-patient relationship.

•Grazina Paegle was a guest speaker at Marion AARP and ESSEX retirees groups. She explained what PAC is trying to do and also explained to the two groups what they can do to help themselves. She has returned to AARP on September 27, 1988 to explain the new medical necessity regulations, which took effect on September 1, 1988, and also asked the senior citizens to let PAC know what type of Medicare problems they are experiencing, so that PAC can present them to the carrier during the monthly meetings at ISMA. The role played by our legislators, Pete Beck and Tracy Boatwright, in bringing the meetings about, was also explained. This is an election year and the elderly should know who is helping them.

•Due to the efforts of the Patient Advocate Committee the patients EOMB forms once again contain the codes under which Medicare is paying the claim. Since there are many instances of code changes by the carrier, this data is very important for anyone helping the patients with their claims, including congressional and social security offices.

•Medical Necessity regulations, which took affect on September 1, 1988, will create a hardship for the elderly because:

1) The majority of elderly patients will probably just pay the bill and not challenge medical necessity denials because many elderly believe that if they say anything critical their benefits will be taken away from them.

2) Most elderly patients have problems understanding the present EOMB form. They will not be in a position to gather the necessary data to challenge medical necessity denials.

3) Most elderly do not have access to xerox machines and many are unable to travel. How are they going to make copies of all the items Medicare requires in order to challenge "Medically unnecessary" denials? Marian Thompson, a member of PAC, has placed this item on the agenda for the next Oversight Coalition meeting.

•The demand for the "Get the Facts" Seminars, developed by Joy Newby, has grown considerably. She has presented   half day seminars and   full day seminars. Although they are designed primarily for physican billing personnel, more and more doctors are also attending these seminars.

•Joy Newby has been retained by the Indiana Academy of Opthalmology to act as their representative during the Oversight Coalition meetings. The opthalmologists have also forged ahead of the ISMA and have activated their own statewide network to deal with carrier-induced problems.

•IPRC and PAC consultants have attracted the attention of physicians in other states. Kathy Hawkins, who manages the freestanding Physician's Billing Service, has been engaged by doctors in other states to do their billing from Grant County. It appears that other states have Medicare problems similar to those which have been solved in Indiana.

CONGRESSIONAL (Continued)

by a physician billing office mistake. Pertaining to many claims originating in Grant County, the two committees (The Patient Advocate Committee and the Insurer Performance Committee of Grant County Medical Society) have been providing such assistance to patients as well as to the Congressional personnel. The emerging oversight coalition could assume this task in the future.

The social security offices are another collection mechanism for problem claims. Senior citizens often go there to get help to refile their claims. There are 26 district offices throughout the state. Each is estimated to handle approximately the same number of cases per year as the office in Marion. It estimates that it files 25 appeals and 35 claims a month for patients. Therefore, the aggregate volume handled by the social security system is about 18,720 ((25+35)X12X26). Again, the clerical personnel of that system are not trained to evaluate Medicare claims. They, too, could use the clearing-house support.

Some senior citizen organizations also provide centers, where their members can go for help pertaining to various topics, including Medicare claims. Their statistics are not in, since these organizations are currently surveying the magnitude of the problem. However, it is quite likely that they will need the clearing-house function also.

RECOMMENDATION TO DEVELOP A FULL-SCALE MEDICARE AND MEDICAID CARRIER OVERSIGHT COALITION (MAMCOC) FOR INDIANA WITH CLEARING-HOUSE MISSION: A JOINT EFFORT BY FEDERAL, STATE AND PRIVATE SECTORS*

by R. D. Paegle,** M.D., H. Clodfelter, R. Jackson, M.D.,
A. Shah, M.D., G. Paegle, and T. Urgena

In Grant County, two committees, the Patient Advocacy Committee and the Insurer Performance Review Committee (IRPC) have documented numerous problems which patients and their doctors have with Medicare carrier induced mistakes. These represent just the tip of the iceberg. Federal budget cuts have reduced Regional HCFA ability to conduct on-site monitoring. During the August 11, 1988 hearings, Senator P. Miller questioned the Director of HCFA Region V. The minutes of the hearings state that the Director testified "that HCFA could not trace a claim that had been incorrectly processed by the carrier and then rejected." He noted "that when the claim was refiled, the record would not indicate the prior error by the carrier." Infusing a large amount of volunteer participation and coordinating it with the existing federal and state facilities could remedy the problem. Therefore the authors recommend the development of a full-scale **MEDICARE AND MEDICAID CARRIER OVERSIGHT COALITION (MAMCOC)** as a joint effort by federal, state and volunteer entities. The emerging coalition now meeting monthly at the headquarters of the Indiana State Medical Society is a good beginning for coordination of the current volunteer efforts.

It is estimated that coordination of the volunteer entities now in place in Indiana could provide 97% of the effort needed for such a joint venture. The remaining 3% would have to be funded by federal, state and other funds.

The remaining 3% would pay for a small staff of professional billing agents with expertise in Medicare coding terminology and billing procedures in different specialities. They could be overseen by a Board of Directors with representation from the major federal, state and volunteer entities, including senior citizens organizations in the state, such as the Indiana chapter of AARP, USA, etc., patient advocacy groups (including the Patient Advocate Committee), representatives from Congressional and Social Security offices, state legislature representatives, physicians from different regions in the state (including the Insurer Performance Review Committee), insurance industry. Liaison personnel from HCFA and the different carriers administering Medicare and Medicaid programs in our state could also be associated with the Board.

MAMCOC could be charged with the following:
A) The claims clearing-house function, i.e. an independent review of the Medicare problem claims submitted to congressional offices, state legislators, social security offices, senior citizens organizations, and a sampling of physicians offices throughout the state. The review would focus on checking whether one of the carriers had committed coding, transcription or computer based errors. If the latter, the coalition staff would follow through and monitor that the carrier remedies its own mistakes. The coalition staff would keep statistical data and forward it to HCFA, GAO (Please note that the Patient Advocate Committee has already been listed as a resource for the Government Accounting Office), etc.

B) The coalition staff would prepare monthly analyses, to identify for its constituent groups the timeliness and accuracy for that period. It would also identify trends in reimbursement mistakes. For example, if physicians billing offices made mistakes, such as using outdated codes or misinterpreting some of the lengthy carrier bulletins, a series of claims might be filed incorrectly. MAMCOC should then suggest remedial actions.

C) It would develop a clearing-house function for other Medicare reimbursement related problems pertaining to the patients and the public. There has to be an entity within the state, other than the carriers own appeal process, where patients, providers and billing agents can take mishandled claims for review.

D) Protect Indiana based carriers and physicians from frequent, and probably unnecessary federal bureaucratic filing and coding changes and other directives, which decrease efficiency, and waste Medicare money and may decrease trust between doctors and patients. Here we refer to Baltimore HCFA directives, not to Regional Office in Chicago. The current Director of the latter is considerably more involved than his predecessor in trying to solve problems in the field. We believe that his budget is also limited, hence hampers his efforts.

It is our firm belief that infusion of 97% private effort combined with reduction of the carriers self-oversight responsibilities and increased carrier accountability will benefit patients and the public.

---

*Presented in part at the Indiana Statehouse during the August 11, 1988 hearings held by the Interim Study Committee on Health Issues.

**R. Paegle is the Co-ordinator of the Insurer Performance Review Committee (IPRC); H. Clodfelter is chairman of the Legislative Committee of the Indiana chapter of the American Association of Retired Persons (AARP); R. Jackson is chairman of IPRC; A. Shah is President of the Grant County Medical Society; G. Paegle is a founding member of the Patient Advocacy Committee; T. Urgena is a member of PAC and the Northern Area Vice-President of the ISMA Auxiliary.

BEST COPY AVAILABLE

NATIONAL SENIOR CITIZENS LAW CENTER
1052 West 6th Street
Suite 700
Los Angeles, CA 90017
Telephone (213) 482-3550

July 26, 1988

BURTON D. FRETZ
EXECUTIVE DIRECTOR

NEAL S. DUDOVITZ
DEPUTY DIRECTOR

Grazina Paegle
804 Quarry Road
Marion, IN 46952

Re: Gray Panthers v. Heckler

Dear Ms. Paegle:

You have asked for my help in responding to an assertion by HCFA that the removal of procedure codes from EOMB forms was mandated by a settlement agreement in litigation brought by the Gray Panthers. I was one of the attorneys representing the Gray Panthers in the lawsuit that challenged the adequacy of the EOMB notice form.

Although I have heard various reports of different incidents in which HCFA has represented that the Gray Panthers settlement agreement prevents it from making improvements in the EOMB form, that is not in fact the case. The settlement agreement required HCFA to adopt an EOMB form with a number of revisions as of the date of the settlement agreement. However, the settlement agreement does not bind HCFA to adhere to that agreed upon form in perpetuity. It was clear that HCFA would have the power to make further improvements in the EOMB form as changes in technology and/or the Medicare program occur.

Furthermore, the omission of the procedure codes from the EOMB form officially adopted in the Gray Panthers settlement was not the result of any feeling that it was bad to include them. They were omitted simply because the notice experts who worked on the revised form felt that they conveyed little useful information to most beneficiaries and unnecessarily cluttered the already complicated EOMB.

In a locale like yours, where apparently beneficiary advocates with special expertise are able to make use of the procedure codes, the Gray Panthers settlement would not prevent continued use of the procedure codes. It seems to me this is implicitly recognized in the correspondence that you included in your letter to me.

Stephen P. Arney, Acting HCFA Regional Administrator, does not say that the Gray Panthers agreement prohibited inclusion of procedure codes, but simply that it omitted them from the information mandated by HCFA to be included on the forms. The fact that some carriers continued to include the procedure codes after the Gray Panthers settlement agreement provides further proof that they were not forbidden, but simply ceased to be required.

I hope that this letter is of use to you in your efforts to obtain the procedure code information that you want on the EOMB. Your group is to be congratulated for its philanthropy in assisting Medicare beneficiaries to obtain the benefits to which they are entitled.

Yours very truly,

Sally Hart Wilson
SALLY HART WILSON
Staff Attorney

SHW:sb

NATIONAL SENIOR CITIZENS LAW CENTER
1052 WEST 6th STREET, SUITE 700
LOS ANGELES, CA 90017

TELEPHONE: (213) 482-3550
FACSIMILE: (213) 482-8009

BURTON D. FRETZ
EXECUTIVE DIRECTOR

NEAL S. DUDOVITZ
DEPUTY DIRECTOR

DATE: 1 / 29 /92

PLEASE DELIVER FAX MESSAGE --

TO: Marion Thompson

FROM: BESS M. BREWER
NSCLC - L.A.

FAX NO: (317) 662 - 8251

FAX NO: (213) 482-8009

TOTAL NUMBER OF PAGES TRANSMITTED (Including This Page) ______

HARD COPY TO FOLLOW: YES: ______ NO: ______ DRAFT: ______

SPECIAL INSTRUCTIONS/COMMENTS: Per our conversation, I am faxing the pertinent portions of the 2nd appeal in the Gray Panthers case, which had a long legal history. Basically, Gray Panthers challenged the inadequacy of the Part B review process for claims under $100. The court agreed that the process in place did not satisfy due process requirements but finally concluded that the improved EOMB in conjunction with the proposed 800 number would satisf due process concerns. The 800 toll-free line was a key element in the court's decision. If your carrier discontinues the toll-free line, it may indeed run afoul of the decision in Gray Panthers. Let me know what happens. Good luck!

PLEASE PHONE Olga Ramirez at (213) 482-3550 if you do not receive this transmission in its entirety. Thank You.

THE INFORMATION CONTAINED IN THIS FACSIMILE MESSAGE IS ATTORNEY PRIVILEGED AND CONFIDENTIAL INFORMATION INTENDED ONLY FOR THE USE OF THE INDIVIDUAL OR ENTITY NAMED ABOVE. IF THE READER OF THIS MESSAGE IS NOT THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISSEMINATION, DISTRIBUTION OR COPYING OF THIS COMMUNICATION IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE IMMEDIATELY NOTIFY US BY TELEPHONE, AND RETURN THE ORIGINAL MESSAGE TO US AT THE ABOVE ADDRESS VIA THE U.S. POSTAL SERVICE. THANK YOU.

[illegible] 887-3390 • FACSIMILE: (202) 785-6792

BEST COPY AVAILABLE

Brief chronolgical account of MSP issue:

May 26, 1993: Letter to Herb Shankroff, Baltimore HCFA requesting information on how MSP problem could occur and continue on for an extended period of time. Other questions also needed answers.

No acceptable answers received. Contacted Senator Lugar's Washington office for assistance. No real response to them either. Senator's office finally sent everything to Bruce Vladek.

November, '93: Telephone call from Baltimore resulting in telephone conference between Baltimore HCFA and PAC. Baltimore promises to investigate and give PAC written report. No report forthcoming.

PAC again requests assistance from Senator Lugar's Washington office.

February '94: Partial response from Carol Walton, Baltimore HCFA.

Senator Lugar's Washington office finally goes back to Mr. Vladek in order to get rest of answers.

April '94: Letter from Ms. Linda A. Ruiz, Baltimore HCFA with rest of answers.

PATIENT ADVOCATE COMMITTEE
238 East Main Street
Gas City, Indiana 46933
(317) 674-7708

Mr. Herb Shankroff
Health Care Financing Administration
BPO OMBA
Room 367 M.E.
6325 Security Blvd.
Baltimore, Md. 21207
May 26, 1993

Dear Mr. Shankroff,

Per our conversation on Monday, May 26, I am sending you copies of the parts of the December, 1992 and January, 1993 Indiana Medicare Oversight Coalition transcripts that apply to MSP.

The question here is why did Chicago give the Carrier the wrong instructions and why did it take so long for them to correct their error and inform the Carrier of it?

As for the problem we discussed regarding the Central Working File. In 1991, the computer decided a beneficiary did not exist and ordered her Medicare claims to be processed under another person's number.

I asked why the Carrier had not checked with the Provider and the patient before making this change. The reply was that: When the Central Working File tells us (the Carrier) to do something, we (the Carrier) are not allowed to question it.

Since this did not seem reasonable, I asked my Congressman at that time, Jim Jontz, to check into it. The result was the letter from Barbara Gagel. Copy enclosed.

This issue surfaced again recently when the Central Working File was, again, changing the Medicare numbers on the beneficiaries claims. When I asked the Carrier if this could be the same type of problem I had pursued in '91, Mr. Steve Crickmore (President/CEO Adminastar Federal) seemed not to remember the letter. I passed a copy of it down to him and it was as if he were seeing it for the first time.

In my own mind, I am certain that if the Chicago Regional Office had sent the Gagel letter on to the Carrier that Mr. Crickmore or a designated representative would have called me as was directed in the Gagel letter.

The questions on this subject are:

1. What became of the Gagel letter?
    - A) Is it still sitting in Chicago?

B) If it was sent to the Carrier, to whom was it directed?

2. Why was I not called if the Carrier received it?

I appreciate your looking into these questions for me and will be expecting to hear from you as soon as you find out the answers.

Sincerely,

(Miss) Marion Thompson
Senior Citizen Representative
Patient Advocate Committee &
Indiana Medicare Oversight Coalition
520 W. Nelson St. Apt. 208
Marion, In. 46952
(317) 668-8180

DEPARTMENT OF HEALTH & HUMAN SERVICES
BUREAU OF PROGRAM OPERATIONS

Health Care Financing Administration

6325 Security Boulevard
Baltimore, MD 21207

FEB 7 1994

Refer to: BPO-B32

Miss Marion Thompson
520 West Nelson Street
Apartment 208
Marion, IN 46952

Dear Miss Thompson:

I am responding to your letters to Congressman Steve Buyer, Senator Richard G. Lugar, Mr. Bruce Vladeck, and Mrs. Patricia Talley expressing your dissatisfaction with a response received from the Health Care Financing Administration (HCFA) addressing several issues of concern to you.

In a telephone conversation with Mrs. Talley and her staff in November 1993 my staff addressed your specific concerns about (1) the method of dissemination of specific Common Working File (CWF) instructions to Medicare contractors and the contractors' ability to question those instructions; (2) the improper processing of claims for the Morgan sisters; and (3) the Medicare Secondary Payer (MSP) limiting charge issue. You then requested that we provide you with a written summary of the entire conversation and the reasons that these problems occurred. My staff agreed to provide you with a written document but indicated that staff from our Chicago Regional Office and Blue Cross and Blue Shield of Indiana (BCBSIN) would need to provide us with some history of the events.

I apologize for the delay in providing this information, but it has taken some time to do the research. This letter is an attempt to provide you with a response that is detailed, concise, and hopefully, fully satisfactory.

You question the dissemination of CWF instructions to contractors and the contractor's ability to question the instructions. CWF instructions are released to all CWF hosts (i.e., nine Medicare eligibility processing sites) who in turn provide the instructions to the Medicare contractors they serve. If any Medicare contractor has questions/problems with the instructions, it may contact HCFA Central Office (CO) or the servicing Regional Office (RO) to discuss the issue.

You asked why the Medicare contractor, when processing claims for the Morgan sisters during calendar year 1991, did not question information contained in CWF and thus inappropriately processed claims for the sisters. In addition, you pointed out that a letter dated January 7, 1992 from Barbara Gagel, the previous Bureau Director, stated that the Chicago Regional Office would be asked to look into the matter and to instruct the carrier to call you to assure you it was in receipt of the proper procedures to correct any future problems created by the CWF. You indicated that the Regional Office was unaware of the problem.

Our research indicates that, although the problem has been resolved and the contractor is aware of the proper procedures to correct any problems identified in CWF, a letter may never have been sent to the Chicago Regional Office directing it to notify the carrier of the correct CWF procedures or to contact you to assure that future communications are more successful. This explains why the Regional Office and the contractor were unable to address specific questions regarding the January 7 letter. We apologize for the inconvenience this error in communication has caused you.

The Morgan sisters' problem occurred when HCFA began using a new computer claim eligibility and payment system which is known as the Common Working File. When designing the CWF we assigned, to nine CWF processing sites, files containing records for more than 30 million Medicare beneficiaries. This was a very tedious process and HCFA used a complex methodology to assign each of the 30+ million beneficiaries to one of the nine hosts.

In the case of the Morgan sisters, Dorothie Morgan's Health Insurance Claim Number (HICN) was never assigned to any CWF host. We can only speculate why this happened. There are verification techniques built into computer systems to ensure that all records read by the computer are, in fact, processed or handled. We simply do not know exactly how the error occurred.

When the contractor received a claim for Dorothie, whose HICN was not in CWF, it assumed the provider had submitted the wrong health insurance claim number and changed it. The contractor should have had HCFA assign the HICN to a CWF host.

Lastly, you indicated that for at least 2 years the Chicago Regional Office improperly gave the contractor instructions that providers could charge anything they want in the MSP context. HCFA recognizes that claims for which Medicare is the secondary payer present a complication when providers attempt to comply with Medicare charge limits. Medicare has no authority over payments made by primary payers. If there are unpaid balances after the primary insurer has paid the claim based on its payment policies, a claim may be submitted to Medicare for consideration of any supplemental payment that may be payable based on Medicare payment policies for these services. The Medicare law does not make any exceptions on the charge limits because the Medicare payment is supplemental. The charge limit of 115 percent of Medicare's fee schedule amount applies. In some cases, the payment methodology is such that the combined payment from the primary insurer and Medicare may exceed the 115 percent limit. As a practical matter, providers will not be considered in violation of the charge limits if they do not collect any additional amount from the beneficiary. If the combined amount from both payers is less than 115 percent of the Medicare fee schedule amount, providers may only collect up to that limit from the beneficiary even if the billed amount is greater than the limit.

At the present time, we are not reviewing Medicare Secondary claims for excess limiting charges. However, HCFA is examining revisions to MSP claims processing procedures which will allow us to correctly calculate and report excess limiting charges to the providers. In the meantime, we expect providers to act in accordance with the guidelines contained in the previous paragraph. These guidelines were sent to all Medicare carriers. The carriers will publish them in Medicare Bulletins.

We appreciate your bringing these matters to our attention. Should you have questions in the future, the Chicago Regional Office would be in the best position to address them in an expeditious manner.

Sincerely,

Carol J. Walton

Carol J. Walton
Director

cc:
Congressman Buyer
Senator Lugar
MSP Coordinator, Chicago Regional Office

BEST COPY AVAILABLE

A CONCURRENT RESOLUTION urging the Administration to support and assist the other 49 states in creating Medicare Oversight Coalitions like the one existing in Indiana.

Whereas, the Medicare system is extremely complex and constantly changing; therefore, providers can never be sure of how to properly file claims;

Whereas, Existing problems with the carriers' claims processing denies patients and providers the assurance of receiving proper reimbursement on Medicare claims; and

Whereas, The Indiana Medicare Oversight Coalition is working to the advantage of patients, providers, and the carrier and is striving to correct existing problems;
Therefore,

Be it resolved by the White House Conference on Aging and the Administration concurring:

Section 1. That the Administration and the Congress of the United States will support and assist the other 49 states in creating Medicare Oversight Coalitions like the one existing in Indiana.

Section 2. That the membership of the coalition should include representatives of carriers, providers and the billing agents, the state medical association, and at least one representative should be a senior citizen.

Section 3. That the subjects addressed by this coalition should include:

(1) the proper filing and coding of claims;
(2) changes in filing and coding procedures;
(3) changes in Health Care Financing Administration (HCFA) or carrier policies;
(4) problems with processing and payment of claims by the carrier.
(5) trends in problems reported by the senior citizen representative;
(6) problems the carrier has been able to identify when receiving or processing claims;
(7) problems the state medical association has been able to identify through reports from their members, and
(8) other items the state may choose to include.

Section 4. The goals of the coalition should be:

(1) increasing proficiency in filing and processing claims
(2) the establishment of responsibility for errors made at the carrier and provider levels;
(3) the assurance of proper processing and payment of claims in a timely manner; and

BEST COPY AVAILABLE

(4) consulting with carriers regarding HCFA proposals for changes.

Section 5. That the White House Conference on Aging transmit a copy of this resolution to the President of the United States, the president pro tempore of the senate and speaker of the house of representatives of the United States.

○

ISBN 0-16-046799-3

90000

9 780160 467998

180